NYS Child Abuse: Identification and Reporting

The New York State Nurses Association (NYSNA) has been approved by the New York State Education Department (NYSED) to provide this course for all mandated licensed healthcare providers, certified teachers and social workers. This program is designed as a distance learning, self-study program which meets the New York State child abuse recognition and reporting requirements.

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This program has been awarded 2.0 CHs through the New York State Nurses Association Accredited Provider Unit.

The New York State Nurses Association is accredited by the International Association for Continuing Education and Training "IACET" and is authorized to issue the IACET CEU.

The New York State Nurses Association is authorized by IACET to offer 0.2 CEUs for this program.

This course is intended for RNs and other healthcare professionals. **In order to receive contact hours/CEUs, participants must read the course materials, pass an examination with at least 80%, and complete an evaluation.** Contact hours/CEUs will be awarded for this course until **December 17, 2018**.

All American Nurses Credentialing Center's *(*ANCC) accredited organizations' continuing nursing education credits are recognized by all other ANCC accredited organizations. Most states with mandatory continuing education requirements recognize the ANCC accreditation/approval system. Questions about the acceptance of ANCC contact hours to meet mandatory regulations should be directed to the professional licensing board within that state.

NYSNA has been granted provider status by the Florida State Board of Nursing as a provider of continuing education in nursing (Provider number 50-1437).

NYSNA wishes to disclose that no commercial support or sponsorship has been received.

How to Take This Course

Please take a look at the steps below; these will help you to progress through the course material, complete the course examination and receive your certificate of completion.

1. **REVIEW THE OBJECTIVES**

   The objectives provide an overview of the entire course and identify what information will be focused on. Objectives are stated in terms of what you, the learner, will know or be able to do upon successful completion of the course. They let you know what you should expect to learn by taking a particular course and can help focus your study.

2. **STUDY EACH SECTION IN ORDER**

   Keep your learning "programmed" by reviewing the materials in order. This will help you understand the sections that follow.

3. **COMPLETE THE COURSE EXAM**

   After studying the course, click on the "Course Exam" option located on the course navigation toolbar. Answer each question by clicking on the button corresponding to the correct answer. All questions must be answered before the test can be graded; there is only one correct answer per question. You may refer back to the course material by minimizing the course exam window.

4. **GRADE THE TEST**

   Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. If you do not pass the exam on your second attempt, you will need to purchase the course again.

5. **FILL OUT THE EVALUATION FORM**

   Upon passing the course exam you will be prompted to complete a course evaluation. You will have access to the certificate of completion **after you complete the evaluation**. Be sure to print the certificate and keep it for your records.

Upon successful completion of this course, results are uploaded electronically to the NYSED, Licensing Division **every day at 4 p.m**. NYSED will not process any record that does not have the full nine-digit social security number noted for the user (*see IMPORTANT note below*). **Please understand the NYSED requires a minimum of 3 business days to update your state record.**

IMPORTANT: If you did not enter, or, do not have a social security number, you will need to send a copy of your certificate of completion to the NYSED yourself. Nurses should fax their certificate of completion to (518) 474 – 3398, or e-mail your certificate of completion directly to opunit4@nysed.gov. All other professionals should contact the NYSED, Office of the Professions directly at (518) 474 -3817 to contact your specific professional unit and attain fax and/or e-mail information.

About the Authors

This course was designed by a team of experts in the Nursing Education and Practice Department of the New York State Nurses Association (NYSNA). The course was updated in June 2007 by **Cheryl J. Collins, RN, LMHC.** Ms. Collins is a nurse and mental health counselor who has worked in the addictions field for the past fifteen years. She co-founded a community based 350-hour training program for Credentialed Alcohol and Substance Abuse Counselors and currently teaches several classes within that curriculum. Ms. Collins is self-employed, developing courses for several human service agencies in the Capital District of New York and in Florida, where she currently resides.

This course was updated in 2011 by **Victoria Greenwood, MS, RN**. Ms. Greenwood is employed as an educator at St. Peters Hospital, in Albany, New York. Additionally, Lynn McNall, MS, RN, then Associate Director in the Nursing, Education and Practice Program at NYSNA, reviewed and updated the course in March of 2012.

In September 2015, this course was reviewed and updated by **Lucille Sollazzo, BSN, RN**. Ms. Sollazzo is employed as an Associate Director in the Nursing Education and Practice Department at the New York State Nurses Association, in New York, NY.

The authors wish to declare they have no vested interest.

Objectives

Upon completion of this course, the learner will be able to:

- Define what constitutes "abuse," "maltreatment," and "neglect" according to the New York State Family Court Act and Social Services Law.
- Distinguish among various behavioral and environmental characteristics of abusive parents or caregivers.
- Identify what equipment and chemicals may be signs of a clandestine methamphetamine lab.
- Define “drug-endangered child” and outline how to report child endangerment.
- Identify physical and behavioral indicators commonly associated with physical abuse, maltreatment, and/or neglect.
- Contrast the physical and behavioral indicators of sexual abuse.
- Identify the professional’s role in child abuse identification and reporting.
- Describe the actions in caring for abused/maltreated children and their families/caregivers.
- Describe situations in which mandated reporters must report suspected cases of child abuse, maltreatment and/or neglect.
- Describe what constitutes "reasonable cause to suspect" that a child has been abused or maltreated.
- Outline the proper procedure for effectively making a report of suspected child abuse, maltreatment, and/or neglect.
- List what actions certain mandated reporters might take to protect a child in addition to filing a child abuse report.
- Describe the legal protections afforded mandated reporters and the consequences for failing to report.

Course Introduction

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Child abuse and neglect are seen in many areas of clinical practice. The content for this course uses the hospitalized child as a specific model. It is important when reviewing the information that professionals realize that the indicators of child abuse, maltreatment and neglect can be applied to all practice settings in which professionals interact with children and their families/caregivers. Child abuse identification and reporting are not limited to one setting.

Chapter 544 of the laws of New York State (1988), as amended, established a requirement for certain professions (see Table 1) to provide documentation of having completed **two hours** of coursework or training regarding the identification and reporting of child abuse and maltreatment (New York State Education Department, Office of the Professions [NYSED, OP], 2009). The law further states that the coursework or training must be obtained from a provider approved for this purpose by the New York State Education Department (NYSED). The New York State Nurses Association (NYSNA) has been approved as a provider and this course meets the training requirements.

In addition, Chapter 394 was amended to provide information for persons in the normal course of their employment, or who travel to locations where children reside, to recognize signs of an unlawful (clandestine) methamphetamine laboratory (New York State Office of Alcoholism and Substance Abuse Services, n.d.).

In 2015, the New York State Office of Children and Family Services (NYSOCFS) revised and published the *Summary Guide for Mandated Reporters in NYS.* This helpful booklet can be downloaded and used as an overview of the material in this course as well as a handy reference on the identification and reporting of child abuse, including how to report suspected child abuse to the New York Statewide Central Register (SCR) of child abuse and maltreatment. A copy of the booklet can be obtained at: http://www.ocfs.state.ny.us/main/publications/pub1159.pdf.

Regardless of the mandated reporter's professional discipline or location of provided services, it is important to understand the responsibility of all professionals to be able to recognize child abuse/neglect and to engage in appropriate interventions.

Who Is Mandated to Report

Social Service Law

Section 413 of Social Services Law (SSL) in New York State identifies professionals and officials who are required to report cases of suspected child abuse or maltreatment.

Table 1. Mandated Reporters		
Physician	Registered Physician Assistant	Surgeon
Medical Examiner	Coroner	Dentist
Dental Hygienist	Osteopath	Optometrist
Chiropractor	Podiatrist	Resident
Intern	Psychologist	Registered Nurse
Social Worker	Emergency Medical Technician	Licensed Creative Arts Therapist
Licensed Marriage and Family Therapist	Licensed Mental Health Counselor	Licensed Psychoanalyst
Hospital personnel engaged in the admission, examination, care, or treatment of persons		a Christian Science practitioner
School officials including, but not limited to:		
School Teacher	School Guidance Counselor	School Psychologist
School Social Worker	School Nurse	School Administrator
Other personnel required to hold a teaching or administrative license or certificate		
Social Services Worker	Day Care Center Worker	School-Age Child Care Worker
Provider of family or group family day care	Employer or volunteer in a Residential Care Facility defined in subdivision four of section four hundred twelve-a of this title or any other child care or foster care worker	
Mental Health Professional	Substance Abuse Counselor	Alcoholism Counselor
All persons credentialed by the Office of Alcoholism and Substance Abuse Services	Peace Officer	Police Officer
District Attorney or Assistant District Attorney	Investigator employed in the office of a district attorney	Other law enforcement official

The entire current list can be found in Article 6, Title 6, Section 413 of the New York Social Services Law, which can be accessed online through the New York State Legislature's Web site: http://public.leginfo.state.ny.us/menuf.cgi. Click on Laws of New York to access Social Services Law.

New York State Office of Children and Family Services (NYSOCFS) states:

- October 1, 2007, Chapter 193 of the Laws of 2007 were amended for those mandated reporters who work for a school, child care provider, foster care facility, residential care facility, hospital, medical institution or mental health facility, and who have direct knowledge of any allegation(s) of suspected child abuse or maltreatment.
- These persons must personally make a report to the Statewide Central Register of Child Abuse and Maltreatment (SCR) and then immediately notify the person in charge of the institution or his/her designated agent that a report has been made.
- The person in charge, or the designated agent of such person, is then responsible for all subsequent internal administration necessitated by the report. This may include providing follow-up information (ex. relevant information contained in the child's educational record) to Child Protective Services (CPS).

Note: Notification to the person in charge or designated agent of the medical or other public or private institution, school, facility or agency does not absolve the original mandated reporter of his or her responsibility to personally make a report to the SCR. ***A mandated reporter who has direct knowledge of possible child abuse or maltreatment,*** *and not the person in charge of the institution, school, facility, or agency, who does not have direct knowledge of the alleged abuse or maltreatment,* ***must make the initial report to SCR.***

- All initial or subsequent reports made to the SCR shall include the name, title and contact information for every staff person of an institution that is believed to have direct knowledge of the allegations contained in the report. Nothing in Chapter 193, however, is intended to *require* that more than one report from any such institution, school or agency be made to the SCR.
- No medical or other public or private institution, school, facility, or agency shall take retaliatory personnel action against an employee who made a report to the SCR. Furthermore, no school or school official, child care provider, residential care facility provider, hospital or medical institution provider, or mental health facility provider shall impose any conditions - including prior approval or prior notification - upon a member of their staff mandated to report suspected child abuse or maltreatment.
- At the time of the making of a report, or at any time thereafter, such person or official may exercise the right to request, pursuant to paragraph (A) of subdivision four of Section 422 of this article, the finding of an investigation made pursuant to this title or Section 45.07 of the mental hygiene law.

  (NYSOCFS, 2011)

<u>Agency Responsibilities</u>

Any person, institution, school, facility, agency, organization partnership or corporation which employs persons mandated to report suspected incidents of child abuse or maltreatment shall provide all such current and new employees with written information explaining the reporting requirements. The employers shall be responsible for the costs associated with printing and distributing the written information.

Any state or local government agency or authorized agency which issues a license, certificate or permit to an individual to operate a family day care home or group family day care home shall provide each person currently holding or seeking such a license, certificate or permit with written information explaining the reporting requirements (NYSOCFS, 2011).

The person in charge or designated agent, when advised by a mandated reporter that the report was made to the SCR by another mandated reporter, shall confirm with the mandated reporter who made the call that a report was made and accepted by the SCR. The organization should establish a policy as to how this confirmation will be accomplished. When a report is accepted, the SCR will advise the mandated reporter who made the report of the SCR number assigned to the report. Included in the policy should be the process in which the mandated reporter notifies the agency of the SCR number assigned to the report and a way in which other mandated reporters in that organization who would have contact with the child, that a report was made, as every mandated reporter is not required to file a separate report if they know that a report of alleged abuse has been made.

Historical Factors Related to Child Abuse and Maltreatment

Each year in the United States, Child Protective Services (CPS) agencies investigate more than 2 million reports of suspected child maltreatment, 18% of which involve concerns of physical abuse. After investigation, more than 650,000 children are substantiated as victims of maltreatment, and over 1500 child deaths are attributed to child abuse or neglect annually (Christian, 2015).

A National Incidence Study (U.S. Department of Health & Human Services [USDHHS], 2011; Flaherty, et al., 2006; NYSOCFS, 2011) found that only half of the incidents of child abuse were reported by professionals even though they were aware of the suspected abuse! The study found reasons that included:

- Misunderstandings or confusion about the required reporting laws and procedures.
- A lack of awareness or knowledge about the clues or warning signs that signal that abuse is occurring.
- Perceived lack of benefit to the child if the abuse is reported; often influenced by personal, professional beliefs, values, and experiences.

Child abuse and maltreatment can occur in any family regardless of its education, ethnicity, or socio-economic status (NYSOCFS, 2011).

The role of the mandated reporter, while acting in their professional capacity, is to report suspected incidents of child abuse or maltreatment and/or neglect. Professional capacity specifically refers to anytime a person is acting within the scope of their practice and in an employment setting or is carrying out functions that are part of their professional duties and responsibilities (NYSOCFS, 2011).

Childhood is a relatively new concept. Until approximately the 18th century, children were seen as small adults and as property of their parents or caregivers and did not have rights. Unfortunately, child begging and mutilation, as well as infanticide were not uncommon. Indeed in many parts of the world today these actions persist to impact the lives of children. Home imprisonment throughout history was not uncommon; child labor has long been a problem (and remains so in many parts of the world) and the industrial revolution in the Western countries only created yet another means for children to be in servitude.

- In 1873, a 9 year old orphan, living in New York City was physically abused almost daily by her caretaker, who often used a raw-hide whip (New York Society for the Prevention of Cruelty to Children [NYSPCC], 2015).
    - A social worker learned of the child's horrible situation, and despite efforts to intervene on her behalf, found that the law, as well as charitable institutions, was unable to protect the girl.
    - The Society for the Prevention of Cruelty to Animals intervened to protect the child as an abused member of the animal kingdom.
    - In April 1874, the abused child was brought into a New York courtroom to tell her story to a judge, which was the beginning of the children's rights movement.
- The Society for Prevention of Cruelty to Children (NYSPCC) was founded in New York City in 1875 due to this 1873 case.
- In 1969, a female child died prompting the creation of New York State's comprehensive Child Protection Laws (University of Maryland School of Public Policy, Welfare Reform Academy, n.d.).
- In 1987, the beating death of a 6-year-old in New York City reminded New Yorkers very vividly that child abuse was not a crime of the past but continued to exist and was continuing to increase at alarming rates (Florida International University College of Education, 2010).
    - There had been indications that the child was being abused, but this was not reported.
    - Her death led to the NYS requirement that all professionals in order to be licensed or certified must:

1. Complete an educational program on the identification and reporting of child abuse and maltreatment.
2. Be mandated to report child abuse and maltreatment.

Legal Definitions

The following are the definitions provided in New York State Laws (New York Family Court Act §1012 Definitions, 2012):

Mandated Reporter - An individual who is legally required to report whenever he or she has reasonable cause to suspect that a child whom the reporter sees in his/her professional or official capacity is abused or maltreated; or has reasonable cause to suspect that a child is abused or maltreated where the parent or person legally responsible for such child comes before them in his/her professional or official capacity and states from personal knowledge, facts, conditions, or circumstances which, if correct, would render the child abused or maltreated. "Of course, anyone may report any suspected abuse or maltreatment at any time and is encouraged to do so" (NYSOCFS, 2011).

Abuse - Abuse encompasses the most serious harms committed against children.

- An abused child is defined as one who is under eighteen years of age whose parent or other person legally responsible for his/her care:
    - Inflicts or allows to be inflicted upon such child physical injury by other than accidental means.
    - Creates or allows to be created a substantial risk of physical injury to such a child by other than accidental means which would be likely to cause death or serious or protracted disfigurement or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ.
    - Committed or allowed to be committed a sex offense against a child.
    - Allows, permits, or encourages such child to engage in any act described in Article 263 of the NYS penal law (e.g., obscene sexual performance, sexual conduct, prostitution).
    - Committed any of the acts described in §255.5 of the NYS penal law (e.g., incest).

- In New York State, an abused child can also mean:
    - A child residing in a group residential care facility under the jurisdiction of the New York State Office of Children and Family Services (NYSOCFS), Division for Youth (DFY), Office of Mental Health (OMH), Office for People With Developmental Disabilities (OPWDD), or the State Education Department (NYSED).

OR

    - A child with a handicapping condition who is 18 years or older who is defined as an abused child in residential care and who is in residential care in one of the following facilities: NYS School for the Blind (Batavia), NYS School for the Deaf (Rome), a private residential school which has been designed for special education, a special act school district or a state-supported school for the deaf or blind which has a residential component.

Maltreatment - Maltreatment means that a child's physical, mental, or emotional condition has been impaired or placed in imminent danger of impairment, by the parent's or legal guardian's failure to exercise a minimum degree of care.

- A maltreated child includes a child:
    - Less than eighteen years of age, defined as a neglected child by the New York Family Court Act §1012 (2012).
    - Who has had serious physical injury inflicted upon him/her by means other than accidental.
    - Eighteen years of age or older, who is neglected and resides in one of the special residential care institutions previously listed.

Neglect - A neglected child (a child less than eighteen years of age), is defined as a child whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his/her parents or other person legally responsible for his/her care to exercise a minimum degree of care (New York Family Court Act §1012, 2012):

- In supplying the child with adequate food, clothing, shelter, or education, or medical, dental, optometric or surgical care, though financially able to do so or offered financial or other reasonable means to do so.
- In providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, including the infliction of excessive corporal punishment.
- By misusing a drug, drugs, or alcohol to the extent that he or she loses self-control of his/her actions.
- By any other acts of similarly serious nature requiring the aid of the court.
- Whom his/her parents or other person legally responsible for the child's care has abandoned.
- Poverty or other financial inability to provide for the child is not maltreatment.

In New York State, an emotionally neglected child is defined in the Family Court Act §1012 (2012) as:

- A state of substantially diminished psychological/intellectual functioning in relation to such factors as failure to thrive, control of aggression/self-destructive impulses, ability to think and reason, or acting out and misbehavior.
- Impairment clearly attributable to the unwillingness or inability of the parent or other person legally responsible for the child to exercise a minimum degree of care to the child.

In New York State, a neglected child in residential care (including facilities operated by the Department of Social Services [DSS], Division for Youth [DFY], Office of Mental Health [OMH], Office for People with Developmental Disabilities [OPWDD], or the State Education Department [NYSED]) means a child whose custodian impairs, or places in danger of impairment, the child's physical, mental or emotional condition:

- By intentionally administering to the child any prescription drug not ordered.
- Failing to adhere to standards for the provision of food, clothing, shelter, education, medical, dental, optometric or surgical care, or the use of isolation or restraint.
- Failing to adhere to standards for the supervision of children by inflicting or allowing to be inflicted physical harm or risk of harm.
- Failing to conform to applicable state regulations for appropriate custodial conduct.

Person Legally Responsible - A legal caregiver or person legally responsible, in accordance with §1012(g) of the NYS Family Court Act (2012), is a:

- Parent
- Guardian
- Foster parent
- Custodian
- Any other person responsible for the child's care at the relevant time

TEST YOURSELF QUESTION #1:

Under New York State law, is it possible for an individual over 18 years of age, who has a disability and resides in a New York state-approved residential care facility, to be classified as an abused child?

A. No, since the person is over the age limit.
B. No, since the person is considered a ward of the state.
C. Yes, this person can be included in this classification.
D. Yes, but only if mentally compromised.

Please turn to page 57 for answer.

Key Assessment Factors

Characteristics of abusive parents or caregivers can be identified by careful assessment that includes:

• Parent/caregiver history • Parent/child history • Environmental factors

Child abuse should receive the same logical, step-wise diagnostic work-up, treatment, and management as any other serious condition. The challenge is to recognize the potential for child abuse early and to intervene on a primary, rather than secondary, level.

American culture, on the whole, accepts and condones the use of physical discipline as normal practice in the adult-child relationship. There is definitely room for learning in parenting styles. However, the message from the caregiver to the child must be one of safety.

Parent/Caregiver History

Items in the personal history of the parent/caregiver that should be seen as “red flags” include (Prevent Child Abuse New York, 2009; Hornor, 2005; NYSOCFS, 2011):

- Parent was abused or neglected as a child.
- Lack of friendships or emotional support:
    - Isolated from supports such as friends, relatives, neighbors, community groups.
    - Lack of self-esteem, feelings of worthlessness.
- Marital problems of the parents (and grandparents):
    - May include intimate partner violence.
- Physical or mental health problems or irrational behavior.
- Life crisis:
    - Financial debt.
    - Unemployment/underemployment.
    - Housing problems.
    - Other significant life stressors.
- Alcohol/substance abuse of parents or grandparents.
- Adolescent parents.

Parent/Child History

Items in the history between the parent and child that should be seen as “red flags” include (Prevent Child Abuse New York, 2009; Jenny, 2007; NYSOCFS, 2011):

- Parents have unrealistic expectations of child's physical and emotional needs. (Note: mentally/developmentally disabled children are particularly vulnerable.)
- Parent's unrealistic expectations for child to meet parent's emotional needs:
    - Role reversal.
    - Children viewed as "miniature adults".
- Absence of nurturing child-rearing skills:
    - Violence/corporal punishment is accepted as unquestioned child-rearing practice within the parent's culture.
    - Violence is accepted as a normal means of personal interaction.
    - Parent is cold and rejecting.
    - Parent seems unconcerned about child.
- Delay or failure in seeking health care for child's injury, illness, routine checkups, immunizations, etc.
- Parent views child as bad, evil, different, etc.

Environmental Factors

Environmental factors that should be seen as “red flags” include (Prevent Child Abuse NY, 2009; Dubowitz & Bennett, 2007; Hornor, 2005; NYSOCFS, 2011):

- Lack of social support. (Note: there may be an inability to ask for and receive the kind of help and support parents need for themselves and their children.)
- Homelessness.
- Disorganized, upsetting home life.

Behaviors of Parent/Caregivers of Abused Children

Behaviors of parent(s)/caregiver(s) of abused children that should be seen as “red flags” include (Dubowitz & Bennett, 2007; Hornor, 2005; NYSOCFS, 2011) the behaviors listed in Table 2. Both the abusing and non-abusing parent are ultimately responsible.

Table 2. Behaviors of Parent(s)/Caregiver(s) of Abused Children

• Offers contradictory histories.	• Attempts to conceal child's injury.
• Presents a history of family discord.	• Exhibits loss of control.
• Has unrealistic expectations of the child.	• Over- or under-reacts to child's condition.
• Hospital "shops," delays in getting care.	• Refuses to give consent for diagnostic workup.
• Complains about issues unrelated to child's condition.	• Misuses alcohol or other drugs.
• Is very protective or jealous of the child.	• Seems unconcerned about child. o Reluctant to give information. o Blame the child's injury on siblings or others.
• Cannot be located.	
• Provides explanation that is inadequate or inappropriate for child’s injury.	

TEST YOURSELF QUESTION #2:

Family histories can reveal clues that suggest further investigation is warranted if child abuse is suspected. Which of the following is such a clue?

A. Grandparents minimally involved.
B. Parent who stutters.
C. Single parent family.
D. Parent was abused as a child.

Please turn to page 57 for answer.

Methamphetamine and Children at Risk

Thousands of children are neglected every year after living with parents, family members, or caregivers who are using or cooking methamphetamine (meth). Children who reside in or near meth labs are at great risk of being harmed by toxic ingredients and noxious fumes. They are known as ***drug-endangered children*****.** Children who live at or visit drug-production sites or who are present during drug production face a variety of health and safety risks, including:

- Malnourishment and suffering are the effects of physical and/or sexual abuse.
- Low level exposures via inhalation, absorption, or ingestion of toxic chemicals, drugs, or contaminated foods that may result in nausea, dizziness, lack of coordination, chest pain, eye and tissue irritation, and chemical burns.
- High level exposure to toxic chemicals can produce shortness of breath, coughing, and death.
- Burns to their lungs or skin from chemicals, fire and explosions; some may die in explosions and fires.
- Chronic exposure of the chemical used in meth manufacture may cause cancer, and can damage the brain, liver, kidney, spleen, and immunologic system.
- Abuse and neglect; many have behavior problems as a result of neglect.
- Hazardous lifestyle (presence of booby traps, firearms, code violations, poor ventilation).

Understanding what to look for, identifying symptoms of methamphetamine use, and recognizing signs of a clandestine methamphetamine laboratory are critical in assessing a child's environment (Swetlow, 2003).

<u>Methamphetamine</u>

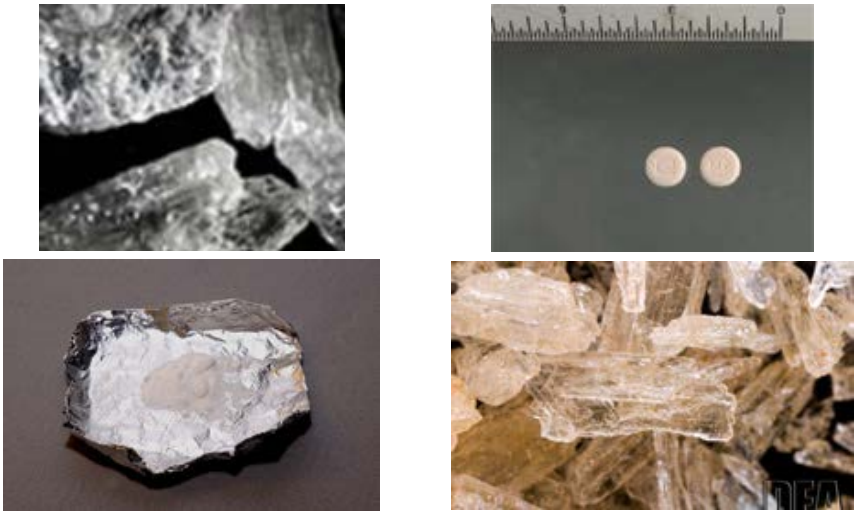
What is Methamphetamine?

Methamphetamine is a potent central nervous system stimulant. Meth can be smoked, snorted, injected or administered orally. Users refer to meth as “crank,” “speed,” “crystal,” or “ice” (National Institute on Drug Abuse, 2013).

What Does Methamphetamine Look Like?

Meth is available as a crystalline powder or in rock-like chunks. Meth varies in color and may be white, yellow, brown, or pink (National Institute on Drug Abuse, 2013).

Figure 1. Forms of Methamphetamine



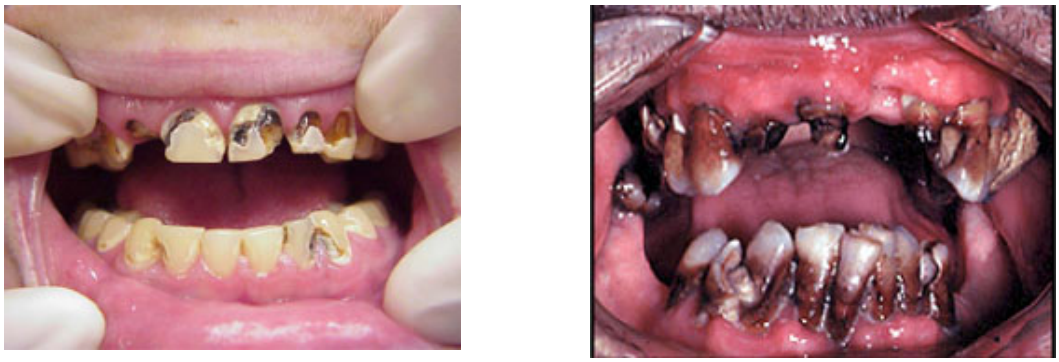
Note: Images of various forms of methamphetamine. Adapted from the United States Department of Justice (USDOJ-DEA) with permission.

Signs of Methamphetamine Use:

Users who smoke or inject meth will experience an intense sensation, called a “rush” or “flash” that lasts only a few minutes and is described as extremely pleasurable. This is followed by a state of high agitation that in some individuals can lead to violent behavior. Snorting or swallowing meth produces a “high” but not a “rush.” The user may exhibit dilated pupils, sweating, dry mouth, flushed skin, and tremors. They often experience increased wakefulness and insomnia, decreased appetite, weight loss, irritability, anxiety, nervousness, and convulsions. They may also exhibit aggressive and psychotic behavior, anxiety, paranoia, and auditory hallucinations.

Long term effects of methamphetamine use include accelerated aging of the skin, hair, and body physique, wearing down of tooth enamel, including decay (National Institute on Drug Abuse, 2013).

Figure 2. Methamphetamine Mouth



Note: Image of *“Meth Mouth*“, showing a long term effect of methamphetamine use. Adapted from *USDOJ-DEA* with permission.

Figure 3. Face of Meth user 11 months after beginning meth use.

Note: Adapted from *USDOJ-DEA* with permission.

What is a Clandestine Laboratory?

The clandestine drug laboratory or clan lab is a mini-chemical lab designed for one purpose: to manufacture illegal drugs quickly and cheaply. Clandestine lab chemists can produce LSD, synthetic heroin and other drugs, but their drug of choice is methamphetamine.

These homemade drugs are dangerous, but the labs are equally dangerous and can be located in any

neighborhood. Toxic chemicals, explosions, fires, booby traps, and armed criminals are all common dangers of clandestine labs (NYSOCFS, 2008).

Clandestine labs can be found in:

- Rural rentals with absentee landlords (homes, barns, mobile homes or outbuildings).
- Urban home or apartment rentals with absentee landlords.
- Trailers and motor homes.
- Motel rooms.
- Houseboats.
- Mini-storage units. These are used to store chemicals, drugs, lab equipment and weapons.

Why Should I Be Concerned?

Methamphetamine users are not the only persons poisoned by this drug. The manufacture of it is extremely dangerous and involves many common household chemicals. These chemicals, alone and in an array of combinations, can be toxic and even lethal. When mixed, these chemicals can damage the central nervous system, liver and kidneys. They can also burn or irritate the skin, eyes, nose, and throat.

The chemicals and their fumes can permeate the wall, carpets, plaster, and wood in meth labs and the surrounding soil, making this a danger to anyone who enters. Producers who operate laboratories in or near residences often produce methamphetamine using common household items including kitchen utensils, dishes, appliances, sheets, and other linens. These items may become contaminated and then fall into the hands of unsuspecting children. Children may ingest toxic chemicals by eating or drinking contaminated foods or beverages or by placing contaminated objects into their mouths.

Ingesting toxic chemicals or methamphetamine may result in potentially fatal poisoning, internal chemical burns, damage to organ function and development, and harm and inhibition to neurological and immunologic development and functioning, respiratory problems, and are known to cause cancer. Many clandestine meth lab operators are untrained in the use of dangerous chemicals. Some meth lab operators experiment with other chemical mixtures, producing unknown toxic and hazardous chemical waste and fumes that may kill several innocent people.

In addition, meth use increases the cost to society for medical and emergency room use. It also contributes to domestic violence, child abuse, automobile accidents, and the spread of infectious diseases such as Hepatitis C and HIV (U.S. Department of Justice, n.d.).

Potential Health Effects

Table 3 lists common ingredients of methamphetamine and the symptoms and health effects potentially experienced from exposure to these ingredients.

Table 3. Ingredients Used to Produce Methamphetamine and Potential Health Effects of Exposure to Them		
Types	**Common Chemicals**	**Symptoms/Health Effects**
Solvents	• Acetone • Ether/starting fluid • Freon • Hexane • Methanol • Toluene • White gas • Xylene	• Irritation to skin, eyes, nose and throat • Headache • Dizziness • Depression • Nausea • Vomiting • Visual disturbances • Cancer
Corrosives/irritants (acids/bases)	• Anhydrous ammonia • Iodine crystals • Hydrochloric acid (muriatic acid) • Phosphine • Sodium hydroxide (lye) • Sulfuric acid (drain cleaner)	• Cough • Eye, skin and respiratory irritation • Burns and inflammation • Gastrointestinal disturbances • Thirst • Chest tightness • Muscle pain • Dizziness • Convulsions
Metals/salts	• Iodine • Lithium metal • Red phosphorus • Yellow phosphorus • Sodium metal	• Eye, skin, nose and respiratory irritation • Chest tightness • Headache • Stomach pain • Birth defects • Jaundice • Kidney damage

External Signs of a Meth Lab

Any single activity may or may not be sole proof that drug dealing or methamphetamine production is occurring. However, a combination of the following may be reason for concern:

- Frequent visitors at all times (odd hours) of the day or night.
- Occupants appear unemployed, yet seem to have plenty of money and pay bills with cash.
- Occupants display paranoid or odd behavior, are typically unfriendly, secretive about activity and may have extensive security systems or signs saying “private property” or “beware of dog”.
- Windows blackened or curtains always drawn.
- Chemical odors coming from the house, garbage or detached buildings.

- Garbage contains numerous bottles, containers, materials such as those listed in the section below, and may be placed in front of neighbor's collection area.

- Coffee filters, bed sheets or other material stained from filtering red phosphorus or other chemicals.

Table 4 lists common household cleaning chemicals/products, and over-the-counter (OTC) medications, frequently used in production of methamphetamine.

Table 4. Common Chemicals Used (in Large Quantities) in Meth Production

Chemical Name:	Commonly Found In:
Acetone	Nail polish remover
Alcohol	Isopropyl or rubbing alcohol
Ammonium sulphate fertilizer	Used to make anhydrous ammonia
Anhydrous ammonia	Farm fertilizer
Calcium bentonite or silica gel	Kitty litter
Carbon dioxide	Dry ice
Drierite	Used to remove water
Ether	Engine starter
Iodine	Teat dip or flakes/crystals
Liquid propane	Propane
Lithium	Batteries
Methanol/alcohol	Gasoline additives
Methylsulfonylmethane (MSM)	Dietary supplements
Muriatic acid	Household cleaning products
Pseudoephedrine/ephedrine	Cold tablets (Sudafed®)
Red phosphorus	Matches/road flares
Salt	Table/rock
Sodium or potassium metal	Kerosene
Sodium hydroxide	Lye
Sulfuric acid	Drain cleaner
Toluene	Brake cleaner
Trichloroethane	Gun scrubber

Table 5 lists some common household equipment used in meth production. Although these are common items, they are uncommon in the large quantities needed to produce meth.

Table 5. Common Equipment Used in Meth Production	
Pyrex or Corning dishes	Rubber tubing/gloves
Jugs/bottles	Pails/buckets
Paper towels	Gas cans
Coffee filters	Tape/clamps
Thermometers	Strainers
Cheesecloth	Aluminum foil
Funnels	Propane cylinders
Blenders	Hotplates
Scales	Mop pails
Measuring cups	Towels/bed sheets
Laboratory beakers/glassware	Plastic storage containers/ice chests

Children Affected by Meth Labs

A significant number of children are injured or killed by methamphetamine labs yearly. These children are exposed to the immediate and ongoing dangers of meth labs that include:

- Increased risk of child abuse and neglect.
- Physical harms.
- Social issues.

What is Happening to Monitor and Decrease the Meth Labs in the US?

- October 2003, the Office of National Drug Control Policy announced a National Drug Endangered Children (DEC) initiative to assist with coordination between existing state programs. This initiative created a standardized training program to extend DEC to states where such a program does not yet exist.
- February 27, 2007, the Drug Endangered Children Act of 2007 (HR 1199) was introduced in the House of Representatives. The act passed in January 2008 and the DEC grant programs were extended for fiscal years 2008 and 2009.
- A variety of agencies are called upon to respond when drug laboratories are identified, including HAZMAT, law enforcement, and fire officials. When children are found at the laboratories however, additional agencies and officials should be called in to assist; including emergency medical personnel, social services, and physicians.

Senator Thomas F. O'Mara of the NYS Senate, introduced a bill to reduce the number of clandestine methamphetamine laboratories, which would implement a series of increasingly severe felony offenses to strengthen the criminal penalties for methamphetamine manufacturing and the possession of meth manufacturing material. As of December 1, 2015, the bill passed in the Senate but had not passed in the Assembly. (Please refer to: http://www.nysenate.gov/press-release/senate-bill-creates-harsher-penalties-methamphetamine-production.) According to the US Department of Justice, methamphetamine is one of the nation's greatest drug threats.

Although coordination among child welfare services, law enforcement, medical services, and other agencies may vary across jurisdictions, interagency protocols developed to support drug-endangered children should generally address:

- Staff training, including safety and cross training.
- Roles and responsibilities of agencies involved.
- Appropriate reporting, cross-reporting, and information sharing.
- Safety procedures for children, families, and responding personnel.
- Interviewing procedures.
- Evidence collection and preservation procedures.
- Medical care procedures.

Actions of the responding agencies should include taking children into protective custody and arranging for child protective services, immediately testing the children for methamphetamine exposure, conducting medical and mental health assessments, and ensuring short and long-term care.

TEST YOURSELF QUESTION #3:

It is necessary for healthcare workers to be aware of the signs of a clandestine methamphetamine lab because:

A. Methamphetamine labs are found only in rural areas or inner city projects.
B. It is considered a danger to children, therefore is inclusive in the definition of child abuse.
C. Methamphetamine users or cookers are the only ones in danger of "poisoning."
D. Children are at risk only when methamphetamine is being cooked.

Please turn to page 57 for answer.

Assessing Physical Symptoms of Child Abuse

Special attention should be paid to injuries that are frequent, unexplained, or are inconsistent with the parent(s)/caregiver's explanation and/or the developmental stage of the child.

The US Department of Justice's booklet, *"Recognizing When a Child's Injury or Illness is Caused by Abuse"* (2002), states:

Repetitive Accidents:

Multiple bruises, wounds, abrasions, or other skin lesions in varying states of healing may indicate repetitive physical assault which may indicate that abuse is occurring.

Cutaneous (skin) Injuries:

The most common manifestations of non-accidentally inflicted injuries are skin injuries. Several Characteristics help to distinguish non-accidental from accidental ones, including their location and pattern, the presence of multiples lesions of different phases, and the failure of new lesions to appear after hospitalizations.

Bruises:

Bruises are due to the leakage of blood into the skin tissue that is produced by tissue damage from a direct blow or a crushing injury. Bruising is the earliest and most visible sign of child abuse. Bruises seen in infants, especially on the face and buttocks, are more suspicious and should be considered non-accidental until proven otherwise. Injuries to children's upper arms, the trunk, the front of their thighs, the sides of their faces, their ears and neck, genitalia, stomach, and buttocks are also more likely to be associated with non-accidental injuries. Injuries to their shins, hips, lower arms, nose, chin or elbows are more likely to signify accidental injury.

Age of Bruise:

When listening to the care-takers explanation of the time of injury, also determine the age of the bruise to see if it is consistent with explanation.

Color of Bruise	Age of Bruise
Red (swollen, tender)	0 – 2 days
Blue, Purple	2 – 5 days
Green	5 – 7 days
Yellow	7 – 10 days
Brown	10 – 14 days
No further evidence of bruising	2 – 4 weeks

Bruise Configurations:

- One of the easiest ways to identify the weapon used to inflict bruises is to ask the caretaker:
    - How were you punished as a child?
- The pattern of skin lesion may suggest the type of instrument used, therefore observe the configuration of the bruise.
- Fixed object bruising:
    - By a fixed object that can only strike one of the body's planes at a time.
    - Such as coat hangers, handles, paddles.
- Wraparound object bruising:

- Bruising by an object that follows the contours of the body and strikes more than one of the body's planes.
- Such as belts, closed- end cords, open-end cords.

- Hands:
  - Can make either kind of bruise, depending on the size of the offender's hands and the size of the child.
- Bite Marks:
  - May help with determining the biter's approximate age based on the size of the marks

Physical and behavioral signs that could indicate abuse include (O'Hara, 2001):

Ocular injuries occur in 40% of abused children and of that only 5% actually present with these injuries, including:		
• Periorbital contusions	• Hyphemas (hemorrhages in the anterior chamber of the eye)	• Injuries caused by fists, fingers, and belts

Bruises, welts, and bite marks (Hornor, 2005; NYSOCFS, n.d.; NYSOCFS, 2011):	
• On face, lips, mouth, neck, wrists, and ankles.	• Regularly appear after absence, weekend, or vacation.
• On torso, back, buttocks, and thighs. (See Figure 4.)	• In various stages of healing.
• Clustered, forming regular patterns reflecting shape of article used to inflict, i.e., electric cord, belt buckle, etc.	• Evidence of a human bite. (A human bite compresses the flesh, animal bite tears flesh and has narrower teeth imprint.)
• On several different surface areas.	• Grab marks on arms or shoulders. (See Figure 6.)
• On both eyes or cheeks, which is always of suspicious origin because only one side of the face is usually injured as the result of an accident. (See Figure 5.)	

NOTE: Photos displayed as Figures 4 – 14 were reprinted with permission from Corporate Graphics Resource.

Figure 4

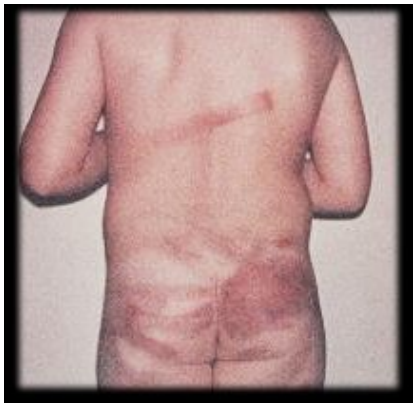


Figure 5

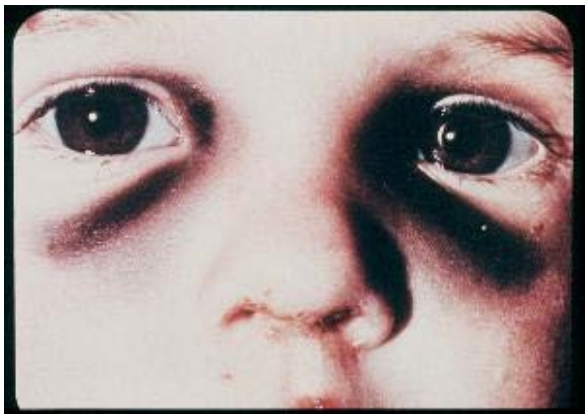


Figure 6

Lacerations or abrasions (Hornor, 2005; NYSOCFS, n.d.; NYSOCFS, 2011):		
• To mouth, lips, gums, eyes	• To external genitalia	• On backs or arms, legs or torso

Burns:	
• Immersion burns by scalding water (sock-like, glove-like, doughnut-shaped on buttocks or genitalia - "dunking syndrome"). (See Figure 7.)	• Steam iron injury. (See Figure 8.)
	• Rope burns on arms, legs, neck, or torso. (See Figure 9.)
• Patterned burn, for example electric burner, iron, etc.	• Cigar burns, cigarette burns, especially on soles, palms, back, or buttocks

Figure 7

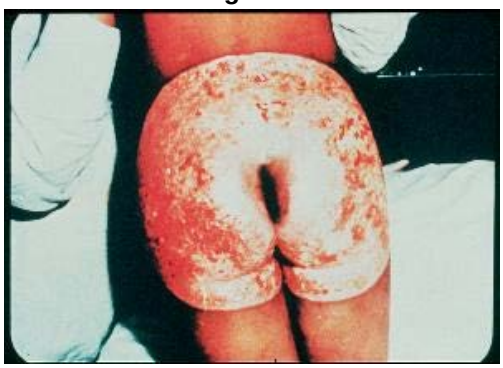


Figure 8

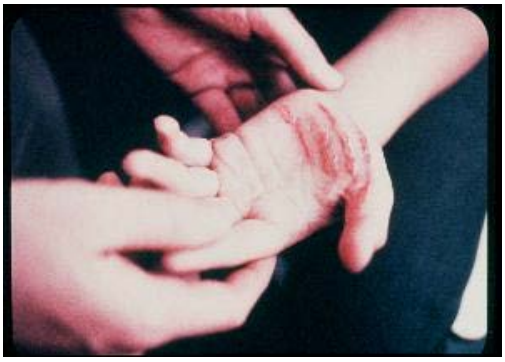
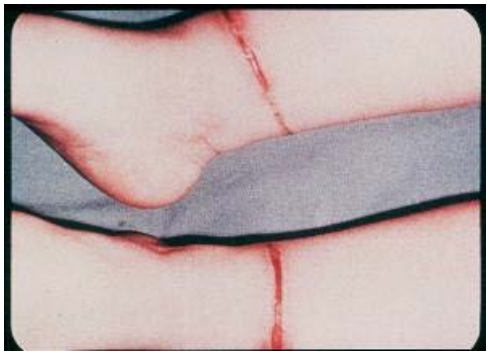


Figure 9



Indications that burns *may not have been accidental*:

- The burns are attributed to siblings.
- An unrelated adult brings the child for medical care.
- Accounts of injury differ.
- Treatment is delayed for more than 24 hours.
- There is evidence of prior “accidents”.
- The lesions are incompatible with the history.
- The burns are more likely found on the buttocks, in the anogenital region and on the ankles, wrists, palms, and soles.
- The burns have sharply defined edges.
- The burns are full thickness.
- The burns are symmetrical.
- The burns are infected or neglected.
- The burns are older than reported history indicates.
- The burns conform to the shape of the implement used.
- The degree of the burns is uniform and they cover a large area.

Indications that burns are *more likely to be accidental*:

- The history is compatible with the observed injury
- The burns are usually found on the front of the body.
    - They occur in locations reflecting the child’s motor activity, level of development, and the exposure of the child’s body to the burning agent.
- The burns are asymmetrical.
- Apparently only one traumatic event has occurred, because the skin injuries are all of the same age.
- The burns are of partial thickness (only part of the skin has been damaged).
- The burns are of multiple depths interspersed with unburned areas and are usually less severe (such as splash burns).

Fractures (Dwek, 2011; Hornor, 2005; NYSOCFS, n.d.; NYSOCFS, 2011):		
• To skull, nose, facial structure.	• Swollen or tender limbs.	• In various stages of healing.
• Skeletal trauma accompanied by other injuries, such as dislocations. (See Figure 10.)	• Fracture "accidentally" discovered in the course of an exam.	• Multiple or spiral fractures. (See Figure 11.)

Certain fractures have high specificity for or strong association with child abuse, particularly infants, whereas others may have less specificity. Approximately 80% of all fractures caused by child abuse occur in children younger than 18 months, and approximately one quarter of fractures in children younger than 1 year are caused by child abuse. Rib fractures, scapular fractures, spinous process fractures and sternal fractures in infants and toddlers have high specificity to child abuse. Physical abuse is more likely to be the cause of femoral and humeral fractures in children who are not yet walking and the percentage of fractures caused by abuse declines sharply after the child begins to walk (Flaherty, Perez-Rossello, Levine, & Hennrikus, 2014).

Figure 10. Epiphyseal Separation

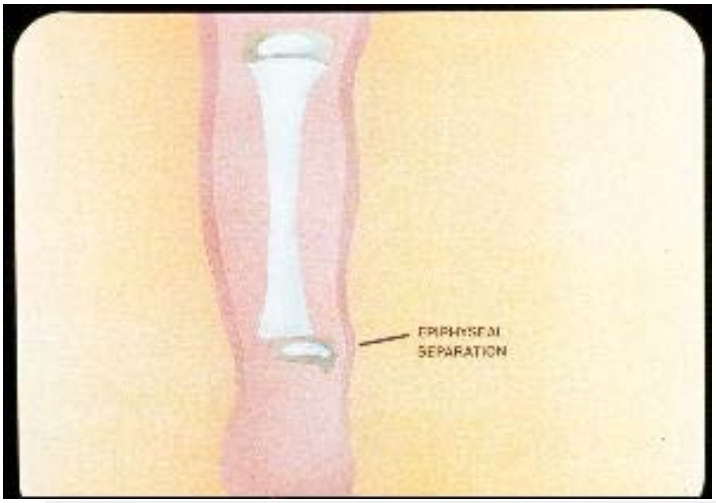
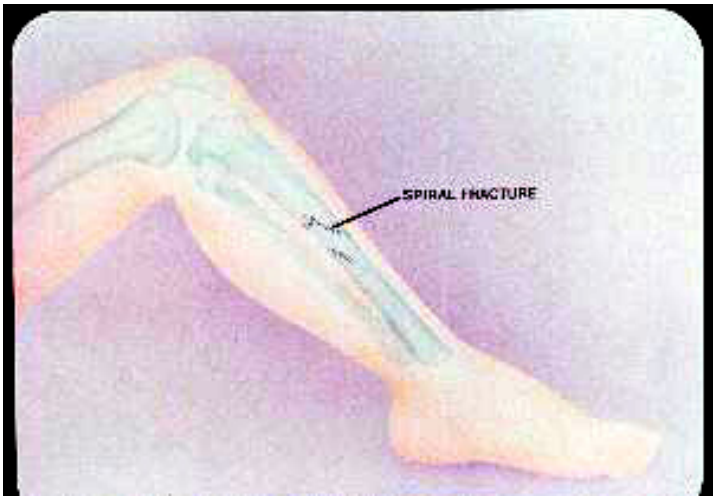


Figure 11. Spiral Fracture



Head Injuries (Dwek, 2011; Magana & Kaufhold, 2015; Hornor, 2005; NYSOCFS, n.d.):		
• Eye injury (detail below).	• Tooth or frenulum injury.	• Jaw and nasal fracture.
• Subdural hematoma (a hemorrhage beneath the outer covering of the brain, due to severe hitting or shaking). (See Figure 12.)		
• Shaken baby syndrome/whiplash shaken infant syndrome. (See Figure 13.)		
• Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling.		
• Retinal hemorrhage or detachment, due to shaking.		

Figure 12. Subdural Hematoma

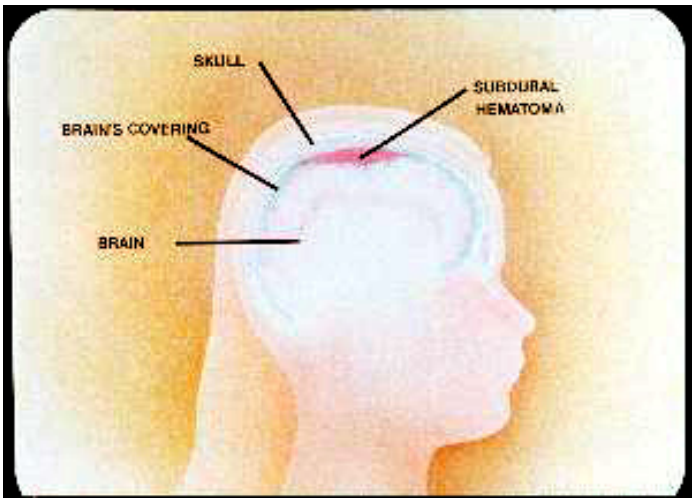


Figure 13. Depiction of a Shaken Child

Symptoms suggestive of parentally-induced or fabricated illnesses (Criddle, 2010; Sugandhan, et al., 2010):	
• Sometimes known as Munchausen Syndrome by Proxy (MSP).	• Example: repeatedly causing a child to ingest quantities of laxatives sufficient to cause diarrhea, dehydration, and hospitalization.

Eye Injuries (US Department of Justice, 2002):

- External eye injuries are so common that they are seldom clear-cut evidence of abuse.
- Two black eyes seldom occur together accidentally.
- The “raccoon eyes” associated with more swelling and skin injury are associated more often with non-accidental trauma.
- Child complaining of pain in the eye and having visual problems can be associated with hyphema which is traumatic entry of blood into the front chamber of the eye (such as from a belt buckle).
- Retinal hemorrhages are the hallmark of shaken baby syndrome and are only rarely associated with some other mechanism of injury.
- Nonaccidental trauma must always be considered in a child under three years of age who has retinal hemorrhages or any traumatic disruption of the structures of the globe of the eye or the skin around the eye.

Shaken Baby Syndrome (SBS) (USDOH, CDC, n.d.):

- Babies less than one year of age (with the highest risk period at 2 - 4 months) are at greatest risk for SBS because they cry longer and more frequently, and are easier to shake than older and larger children.
- SBS injuries have been reported in children up to age five.
- SBS is the result of violent shaking that leads to a brain injury, which is much like an adult may sustain in repeated car crashes. It is child abuse, not play. This is why claims by perpetrators that the highly traumatic internal injuries that characterize SBS resulted from merely “playing with the baby” are false. While jogging an infant on your knee or tossing him or her in the air can be very risky, the injuries that result from SBS are not caused by these types of activities.
- The most common trigger for shaking a baby is inconsolable or excessive crying—a normal phase in infant development.

- Parents and their partners account for the majority of perpetrators. Biological fathers, stepfathers, and mothers' boyfriends are responsible for the majority of cases, followed by mothers.
- In most SBS cases there is evidence of some form of prior physical abuse, including prior shaking.

Babies with SBS, may **exhibit** the following:

Severe: Unresponsiveness, loss of consciousness, breathing problems, no pulse.

Less severe: Change in sleeping pattern or inability to be awakened, vomiting, convulsions or seizures, irritability, uncontrollable crying, inability to be consoled, inability to nurse or eat.

TEST YOURSELF QUESTION #4:

Physical signs that almost always indicate child abuse are:

A. Bruises
B. Lacerations
C. Persistent diaper rash
D. Injuries to both eyes or cheeks

Please turn to page 57 for answer.

Assessing Child's Behavioral Indicators

Children who have been abused may demonstrate some of the following behaviors (Magana & Kaufhold, 2015; Jenny, 2007; Hornor, 2005; NYSOCFS, n.d.; NYSOCFS, 2011; Child Welfare Information Gateway, 2013):

- Wary of contact with adults.
- Apprehensive when other children cry.
- Exhibits behavioral extremes:
    - Aggressiveness.
    - Destructiveness.
    - Withdrawal.
    - Emotionless behavior.
    - Extreme mood changes.
    - Attempts suicide.
- Afraid to go home, has repeated incidents of running away.
- Fear of parents.
- Reports injury by parents.
    - Sometimes blames self, e.g., "I was bad and I was punished."
- Habit disorders:
    - Self-injurious behaviors.
    - Psychological reactions (obsessions, phobias, compulsions, hypochondria).
- Wears long sleeves or other concealing clothing to hide physical indicators of abuse.
    - Often inappropriate for season.
- Manifests low self-esteem.
- Seeks affection from any adult.
- The child shows sudden changes in behavior or school performance.
- Has not received help for physical or medical problems brought to the parents' attention.
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes.
- Is always watchful, as though preparing for something bad to happen.
- Lacks adult supervision.
- Is overly compliant, passive or withdrawn.
- Comes to school or other activities early, stays late, and does not want to go home.
- Is reluctant to be around a particular person.
- Discloses maltreatment.

Maltreatment and Neglect

Just as when observing for physical abuse, professionals must be alert and aware for physical and behavioral signs of possible maltreatment and neglect. Remember that not all of these symptoms are present in all abusive/neglectful situations. Look for patterns, clues, or a combination of indicators (Magana & Kaufhold, 2015; Jenny, 2007; Hornor, 2005; NYSOCFS, n.d.).

Table 6. Physical Indicators	
• Obvious malnourishment, consistent hunger.	• Poor hygiene/inappropriate seasonal dress.
• Failure to thrive (physically or emotionally).	• Unattended physical problems/medical needs.
• Drug withdrawal symptoms in newborns.	• Untreated need for glasses, dental care.
• Speech disorders.	• Lags in physical development.
• Chronic truancy.	• Abandonment.
• Chronic lack of supervision, especially in dangerous activities or for long periods.	

Table 7. Behavioral Indicators	
• Begging or stealing food.	• Failure to thrive.
• Extended stays at school (early arrival or late departure).	• Overly adaptive behavior (inappropriately adult or infantile).
• Attendance at school infrequent.	• Conduct disorders (antisocial, destructive).
• Constant fatigue/listlessness/falling asleep in class.	• Habit disorders (sucking, biting, rocking, head banging).
• Alcohol or drug use/abuse.	• Delinquency (i.e., thefts).
• Runaway behavior.	• Neurotic traits (sleep disorders, inhibited play).
• Psychoneurotic reactions (hysteria, phobias, hypochondria, compulsion).	• Behavioral extremes (compliant, passive, aggressive, demanding).
• Suicide attempts or gestures, self-mutilation.	• Lags in mental, physical, and/or emotional development.

Sexual Abuse

Because most sexual abuse cases do not present overtly apparent physical evidence or indicators, identification and recognition are often very difficult. To compound the problem of detection and identification, the many legitimate fears which child victims of sexual abuse experience make it extremely difficult for them to report the abuse, even to a very trusted adult or friend since their trust has been so violated.

Molested children:

- By vast majority, are molested by family members or friends.
- Experience the fear of betraying a loved one and possibly losing affections forever if they disclose the abuse.
- Fear the overwhelming shame and guilt that disclosure may cause.
- Fear that family members and other significant people in their lives will blame them for the abuse.
- Fear the common threats of being hurt or even killed if they disclose the abuse.
- May retract the disclosure as the family system may begin to place pressure.
- Often decide to live in quiet and devastating isolation with their "secret" rather than risk the realization of their fears.

Child sexual abuse is not a problem uniquely found in only certain geographic areas or among people of certain economic conditions, races, or occupations. There is absolutely no profile of a child molester or of the typical victim. Do not assume that because an alleged offender has an unparalleled reputation for good works in the community or holds a certain job, he or she could not also be a child molester (NYSOCFS, 2011).

Physical Indicators

Table 8. Physical indicators of sexual abuse.
(Denton, Newton, & Vandeven, 2011; Swerdin, Berkowitz, & Craft, 2007; NYSOCFS, n.d.):

• Difficulty in walking, sitting.	• Genital pain, itching.
• Torn, stained, bloody clothing or underwear.	• Bruising, injury to the hard or soft palate. (See Figure 14.)
• Painful urination or urinary tract infections.	• Presence of foreign bodies in vagina or rectum.
• Sexually transmitted diseases, especially in preteens, including venereal oral infections.	• Bruises, bleeding, or any injury in genital, vaginal or anal areas. (See Figure 14.)
• Pregnancy, especially in early adolescent years.	

Remember, the lack of physical evidence makes identification and recognition difficult. Since the vast majority of child molesters are family members or friends, admitting the abuse is very difficult for the child.

Figure 14

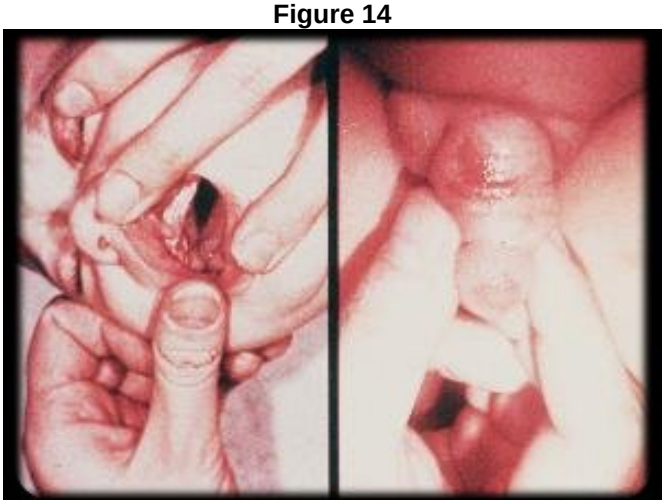


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Table 9. Behavioral indicators of sexual abuse.	
• Low self-esteem.	• Sexual victimization of other children.
• Refusal to participate in/or change for gym.	• Delinquent, truancy, running away.
• Infantile behavior.	• Prostitution.
• Poor peer relationships.	• Extreme, exaggerated fear of closeness or physical contact.
• Withdrawn/elaborate fantasy life.	• Self-injurious activities/suicide attempts.
• Aggressive, disruptive behavior.	• Reports caretaker is sexual assailant.
• Sexually suggestive, inappropriate, or promiscuous behavior or verbalization.	• Expressing age-inappropriate knowledge of sexual relations.

Components of a Sexual Abuse Examination

- Full history and physical examination
- Psychosocial/developmental evaluation
- X-rays and photographs as indicated
- Genital examination
- Appropriate specialty examinations (such as testing for sexually transmitted diseases)
- Daycare and school reports

(NYSOCFS, 2011)

TEST YOURSELF QUESTION #5:

Children are most often physically abused by:

A. Strangers
B. Other children
C. Their teachers
D. Their relatives

Please turn to page 57 for answer.

Hospitalization and the Abused Child

In instances where an abused child is hospitalized, in addition to the treatment of injuries, hospitalization can provide benefits for the abused child and family.

- Respite for all involved parties.
- Exposure to predictable and trustworthy adults.
- Opportunity for the child to develop a positive self-image.
- Interaction of the child and parent in a controlled environment.
- Opportunity for parents to form relationships with supportive professionals.

During hospitalization caregivers must adhere to professional responsibilities:

- The child's safety is the healthcare worker's responsibility.
- Parents should be told New York State law requires that, when the cause of a child's injuries cannot be explained, the child and family are referred to the child protection agency for investigation.
- Parents should be informed that the cause of the child's injuries is uncertain and that further studies and evaluation are necessary.

The information presented in the rest of this lesson can be very useful in dealing with an abused child. Although developed for nurses, the guidelines and principles can be adapted easily by other professionals to fit their own situations.

<u>Assessment</u>

Key Points

- Physical and emotional trauma to child.
- Relationship of parents/caregiver and child.

Objectives: Outcomes of Care

- Physiological and psychosocial well-being of child.
- Freedom from further abuse/neglect.
- Positive parent-child interactions.

<u>Intervention: Specific Professional Actions</u>

- Verify that the case has been reported to appropriate agencies according to state law.
- Promote a trusting relationship with the child:
    - Insure consistent professional care givers.
    - Provide a private, non-threatening atmosphere.
    - Remain calm, don’t overreact.
    - Provide frequent contact (note that cuddling/holding may not be appropriate).
    - Be honest, open, and up-front with the child.
    - Remain supportive.
    - Listen to the child.
    - Stress that it’s not the child’s fault.
- Integrate the child into a normal, daily routine as tolerated.
- Observe closely all interactions between the parent(s)/caregiver(s) and the child.
- Remove the parent(s)/caregiver(s) from the unit if she or he is attempting to harm the child.
- Participate in multidisciplinary treatment meetings regarding the child's progress and status.

- Allow the parent(s)/caregiver(s) to verbalize; listen non-judgmentally.
- Avoid asking threatening questions about any specific incident of abuse.
- Don't interrogate or try to investigate, this is especially important in sexual abuse cases.
- Don't make judgments or promises.

(NYSOCFS, n.d.; NYSOCFS, 2011)

Parent/Caregiver

The parent/caregiver offender or nonoffender should be treated as well. If reunification is a therapeutic goal, certain preconditions must exist, including:

- Offender acknowledgment of abuse.
- Offender assumption of responsibility for the abuse.
- Offender awareness of offending pattern and commitment to change.
- Offender demonstration of willingness to participate in safety plan.
- Nonoffending caregiver acknowledgment of abuse.
- Nonoffending caregiver assumption of responsibility of safety for the child.
- Nonoffending caregiver demonstration of willingness to participate in safety plan.

(Lipovsky & Hanson, 2007)

Teaching and Discharge

- If the child is to be discharged in the custody of parent(s)/caregiver(s), provide guidance in:
    - Specific stages of growth and development to foster realistic expectations of behavior at home.
    - Appropriate child-rearing practice within the framework of the individual family's cultural background.
    - Proper use and methods of discipline (consistency, positive reinforcement).
- If the child is to be placed outside of the home, assist the parents in accepting that the decision has been made for the benefit of the child/family.
- Encourage parents to comply with professional guidance/treatment.
- Collaborate with other healthcare professionals in discharge planning.

Documentation

- All objective evidence of abuse/neglect.
- Child's responses to professional interventions.
- Behavior of parent(s)/caregiver(s) with child.
    - Number, time, and length of visits and the effects on the child.
    - Parent/caregiver's response to child (e.g., eye contact, ignoring child, physical contact).
    - Child's response to parent (e.g., crying, no eye contact, clinging, avoidance).
- Parent(s)/caregiver(s) level of comprehension of all instructions/teaching.

(NYSOCFS, 2011)

Handling Disclosures of Abuse

Recognizing Disclosures

Very seldom will a child disclose abuse immediately after the first incident has occurred. Victimized children often experience a great sense of helplessness and hopelessness and think that nobody can do anything to help them. Also, victimized children may try to make every attempt to protect an abusive parent or they may be extremely reluctant to report any abuse for fear of what the abuser may do to them. Typically, a child may not report abuse for months and even years, particularly if the abuser is someone close to the child.

Sometimes an outcry may not be verbal, but portrayed in a drawing left behind inadvertently for the teacher, the counselor, or a trusted relative to see. Another form of outcry may be seen in a child who will frequently go to the school nurse complaining of vague, somatic symptoms, often without organic basis, hoping that the nurse will guess what has happened. This way, in their minds, they have not betrayed, nor will they be punished since they did not directly report the abuse. Some children, while totally reluctant to report or discuss the abuse, may be more willing to express their apprehensions and anxieties about the perpetrator or the home situation. In some cases, abused children will make an outcry, which may take the extreme form of a suicide gesture or attempt.

Children may disclose abuse in a variety of ways. They may blurt it out to you, especially after you have created a warm nurturing environment. They may come privately to **talk directly and specifically** about what is going on. But more common ways include:

> ***Indirect Hints:*** "My brother wouldn't let me sleep last night." "My babysitter keeps bothering me." A child may talk in these terms because he/she hasn't learned more specific vocabulary, feels too ashamed or embarrassed to talk more directly, has promised not to tell, or for a combination of these reasons.
>
> ***Appropriate responses:*** would be invitations to tell you more, such as "How did that make you feel?" and open-ended questions such as "Can you tell me more?" or "What do you mean?" Gently encourage the child to be more specific. It is important that the child use his/her own language, and that no additional words are given to the child.
>
> ***Disguised Disclosure****:* "What would happen if a girl told someone her mother beat her?" "I know someone who is being touched in a bad way." Here the child might be talking about a friend or sibling, but is just as likely to be talking about her/himself. Encourage the child to tell you what he/she knows about the "other child." It is probable that the child will eventually tell you about whom he/she is talking.
>
> ***Disclosure with Strings Attached:*** "I have a problem, but if I tell you about it, you have to promise not to tell anyone else." Most children are all too aware that some negative consequences will result if they break the secret of abuse. Often the offender uses the threat of these consequences to keep the child silent. Let the child know you want to help him/her. Tell the child from the beginning, that there are times when you too may need to get help with the problem. In order to help, it may be necessary to get some special people involved. The fact that the child has chosen this particular moment to disclose is important. Usually, they will agree to seek help if you talk about it ahead of time. Assure the child that you will respect his/her need for confidentiality by not discussing the abuse with anyone other than those directly involved in getting help. And, if you can explain the process, it may help with initial fear (NYSOCFS, 2011).

Responding to Disclosures

In school, if a child discloses during a lesson, acknowledge the child's disclosure and continue the lesson. Afterward, find a place where you can talk with the child alone. It is best to present child abuse curricula before a playtime or recess so that you have a natural opportunity to talk with children privately if they come forward.

Before notifying anyone outside of your school or agency, you or another designated person should sit down in a quiet room without interruptions and speak with the child. If a child has chosen you as the person in whom to confide, you should take the time to speak with the child about the problem. If that is not possible, ask the child if she/he would feel comfortable discussing it with someone else. If the child indicates that he wants to tell you, you must make every effort to listen and support the child. She/he may not trust another enough to tell.

Multiple interviews should be avoided. The child will have to share the story with many others. When you speak with the child, sit down together. Assure him/her that you are concerned and want to know more and that it's okay to tell you. Go slowly, allowing the child to explain as much as he/she can. Do not suggest in any way that any particular person may have done something to him/her, or, that the child was touched in any particular way. **Let the child talk as much as possible.** Explain, in age appropriate language, that the law requires you to make a report if any child discloses abuse and that the law is there to protect them. Describe for them who will be involved, for example, the social worker, principal and the CPS caseworker.

In the Case of Sexual Abuse:

There are specific guidelines that apply to cases of suspected sexual abuse. Once a child reveals information that makes you suspect sexual abuse, avoid talking in detail with the child about the incident. Often CPS and law enforcement work together to interview a child at the same time. These professionals have been specifically trained in interviewing children.

When Talking to the Child

DO:

- Find a private place to talk with the child.
- Sit next to the child, not across a table or desk.
- Use language the child understands; ask the child to clarify words you don't understand.
- Express your belief that the child is telling you the truth.
- Reassure the child that it is not his/her fault, and that he/she is not bad and did nothing to deserve this.
- Determine the child's immediate need for safety.
- Let the child know you will do your best to protect and support him/her.
- Tell the child what you will do, and who will be involved in the process.

DO NOT:

- Disparage or criticize the child's choice of words or language.
- Suggest answers to the child.
- Probe or press for answers the child is unwilling to give.
- Display shock or disapproval of parent(s), child, or the situation.
- Talk to the child with a group of interviewers.
- Make promises to the child, about "not telling" or how the situation will work out.

Supporting the Child after the Report Has Been Made

If it is necessary for CPS or a law enforcement official to interview the child at the school or agency, you should cooperate and assist by providing access for such an interview. Unless there are compelling reasons against it, a staff member the child trusts should be present during the interview to provide support for the child. (This situation may also arise when the report did not originate from your school or agency.)

NYSOCFS, 2011

Reporting Child Abuse, Maltreatment or Neglect

Reportable Situations

- When a mandated reporter suspects that a child whom the reporter sees in his or her professional/official capacity has been abused/maltreated.
- When the reporter sees the parent/caregiver in an official capacity and the parent/caregiver reports abuse of a child or children.
- When, as an employee, the mandated reporter suspects abuse or neglect he/she immediately notifies the appropriate authority in the agency or facility where he or she is employed. That person then makes the report. It should be noted that the person in charge may not prevent the staff member from making a report if there is reasonable cause to suspect.

Crimes committed against children should be directly reported to law enforcement. If you are uncertain if an incident is criminal you can contact the SCR anyway. SCR staff are trained to make those distinctions or can make a Law Enforcement Referral (LER).

*Examples of Reportable Situations**

- A school principal calls the SCR and reports that a 10-year-old pupil has told him repeatedly for several weeks that he does not get enough to eat at home. The child appears pale and eats excessively at the school lunch program.
- A mother brings her four-year-old daughter to the emergency room because of a vaginal discharge. The child is diagnosed with gonorrhea.
- A five-year-old boy is continually brought to the school nurse for an advanced case of head lice.
- A 12-year-old female, comes to school with two bruises. One is on the upper left arm and one is on the lower area of her neck. She states that her mother was upset yesterday and threw her against the refrigerator.
- A three-year-old is brought to the emergency room and is diagnosed to have second-degree immersion burns.
- A school counselor calls the SCR and states that a child has missed 34 out of a possible 95 days of school. The child has submitted an excuse for 10 of his absences. The school has attempted to contact the parents. The parents have not responded to the contacts.
- A neighbor calls the SCR and states that siblings, a three-year-old and four-year-old, sit on the windowsill every day during warm weather. The family lives in a fourth floor apartment without any screens or bars.
- A mother calls the SCR and reports that she is afraid her husband is going to harm her six-month-old baby. He has on more than one occasion violently shaken the baby when the baby didn't stop crying.
- A grandmother calls the SCR and states that her daughter-in-law treats her eight-year-old grandson terribly. She verbally abuses the child by calling him filthy names and makes him cry.
- A neighbor calls the SCR and states that three young children, who live two trailers down, roam the trailer park all night long vandalizing neighbor's property.
- A 16-year-old boy is repeatedly drinking (two - three times a week) to the point of intoxication. He drinks in front of his mother. The aunt is concerned and calls the SCR.

*Source: NYOCFS, n.d.

Reasonable Cause

A ‘reasonable cause’ to suspect means that based on what physical evidence a person has observed or has been told, combined with their training and experience, they feel that harm or imminent danger of harm to the child could be the result of an act or omission by the person legally responsible for the child.

The reporter need not be absolutely certain that the injury or condition was caused by neglect or by non-accidental means; the reporter should only **BE ABLE TO ENTERTAIN THE POSSIBILITY THAT IT COULD HAVE BEEN NEGLECT OR NON-ACCIDENTAL** in order to possess the necessary "reasonable cause" (NYSOCFS, 2011).

The law provides for, and in certain instances requires, the reporting of suspected cases of child abuse and maltreatment because the child protective system is based on investigation and intervention. The sooner a case is reported, the better the chances of protecting the child and rehabilitating the family (New York State Assembly, Committee on Children and Families, 2014).

Suspicion

Certainty is not required; it is enough for the mandated reporter to distrust or doubt what she or he personally observes or is told. In child abuse cases, many factors can and should be considered in the formation of that doubt or distrust. Physical and behavioral indicators may also be helpful in forming a reasonable basis of suspicion. Explanations that are inconsistent with observations and/or knowledge may be a basis for reasonable suspicion. Although these indicators are not diagnostic criteria of child abuse, neglect, or maltreatment, they illustrate important patterns that may be recorded in the written report when relevant (NYSOCFS, 2011).

Imminent Danger

Imminent danger means that the child is placed at immediate risk or substantial risk of harm. The standard to apply is reasonableness. Ask yourself: Is it reasonable to believe an intervening factor could occur? If the answer is yes, then there is no imminent danger. If the answer is no, then there is reasonableness to assume that harm could occur and there is imminent danger.

TEST YOURSELF QUESTION #6

Is it true that in order to possess the necessary "reasonable cause" to file a report of child abuse, the reporter must be certain that the injury was caused by neglect or non-accidental means?

A. Yes; otherwise, the reporter is making a libelous claim.
B. Yes; otherwise, the reporter may have his/her license temporarily suspended.
C. No; any suspicion, even without reasonable cause, must be reported.
D. No; if there is a professional judgment, a report should be filed.

Please turn to page 57 for answer.

Reporting Procedures

When to Report

- Immediately, by telephone, at any time of day, seven days a week.
- A written report must be filed within 48 hours of the verbal report.

How to Report

- Mandated reporters who learn of abuse, maltreatment, or neglect in the course of their employment should make verbal telephone reports.
    - The statewide toll-free telephone number for reporting is **1-800-635-1522**.
    - Calls to this hotline are given priority.
- Reports of suspected abuse by anyone other than a mandated reporter (neighbor, relative, friend, etc.) or if you are not acting in your official capacity, the call should be made to the non-mandated reporter hotline.
    - Call the New York State Central Register of Child Abuse and Maltreatment (SCR) toll-free at **1-800-342-3720**.
- Two counties have their own localized hotlines that may be used instead of the SCR:
    1. Monroe County: **(585) 461-5690**
    2. Onondaga County: **(315) 422-9701**

- A written report, signed by the reporter, must be filed with the local Child Protective Services (CPS) within 48 hours of the verbal report.
    - You may request the address of the investigative district from the child protective specialist at the time you make the oral report to the SCR.
- Reporters may wish to maintain careful notes for their own personal records, noting such things as dates, times, places, names of individuals involved in any reporting incident, etc.

Subject of the Report

For purposes of reporting suspected cases of child abuse and maltreatment to the SCR and CPS, it is important to understand the definition "subject of the report" as defined by Section 412.4 of the Social Services Law.

"Subject of the Report" means any:

- Parent, guardian, custodian, or other person 18 years of age or older:
    - Who is legally responsible (as defined in Section 1012(g) of the Family Court Act) for a child reported to the SCR.
    - And who is allegedly responsible for causing, or allowing infliction of, injury, abuse, or maltreatment to such child.

"Subject of the Report" also means an:

- Operator of, employee or volunteer in a home operated or supervised by an authorized agency, the Division for Youth, or an office of the Department of Mental Hygiene, or a family day-care home, day-care center, group family day-care home, or a day-services program,
    - Who is allegedly responsible for causing - or allowing the infliction of - injury, abuse or maltreatment to a child who is reported to the Central Register.

Of course, abuse and maltreatment may be caused by individuals other than a parent or person legally responsible for the child's care, such as neighbors or strangers. Such individuals might not fit the legal definition of "subject of the report."

When the alleged perpetrator of child abuse or maltreatment cannot be the "subject of a report" (as defined in Section 412.4 of the Social Services Law [SSL]), enforcement authorities should be contacted directly. If a call is received by the SCR and the person allegedly responsible for the abuse and maltreatment cannot be the subject of the report, and SCR believes that the alleged acts or circumstances described by the caller may constitute a criminal and immediate threat to the child's health or safety, the SCR is required by law to transmit the information contained in the call to the appropriate law enforcement agency, district attorney, or other public official empowered to provide necessary aid or assistance.

Reporting of Child Abuse in an Educational Setting

Written Statement of Parental Rights

Amendment to Section 100.2 of the Regulations of the Commissioner of Education Pursuant to NYS Education Law Sections 101, 207, 305, 1128, 1132, and 3028-b and Sections 12 and 13 of Chapter 180 of the Laws of 2000 added a requirement that a written statement be provided to the parent of a child who is the subject of an allegation of child abuse in an educational setting. This sets forth rights, responsibilities, and procedures for parents, employees, school administrators, and superintendents. The amendment requires reporting and notification if a written report, that alleges that a child has been abused in an educational setting, is made. This is apart from the rules and regulations concerning the recognition and reporting of child abuse.

What to Include in the Report

Telephone Report:

- The effect on the child.
- The names and addresses of the child, parent(s), and/or other persons responsible for the child's care. The role of the parent (or persons legally responsible).
- The child's name, age, gender, race, special needs, and medications.
- The nature and extent of the child's injuries, abuse, or maltreatment, including any evidence of prior injuries, abuse or maltreatment to the child or siblings or is the child at risk for harm, by who, and how. Ongoing pattern or single episode.
- The name of the person or persons responsible for causing the injury, abuse, or maltreatment.
- Family composition.
- The source of the report.
- The person making the report and where she/he can be reached.
- The name, title, and contact information of every staff person of an agency/institution believed to have direct knowledge of the allegations in the report.
- The actions taken by the reporting source, including the taking of photographs or X-rays, custody of the child, and medical examiner or coroner notification.
- Any additional information that may be helpful.
    - Any personal safety issues for the local CPS worker.
    - Any related issues for the local caseworker to know (weapons, dogs, etc.).
    - The mandated reporter’s contact information.
    - Any identifying information so the CPS agency can locate the child.
    - Is there the need for an interpreter?
    - Does the child have any special needs? What are they?
    - Is the child on any medications?
    - Are there any related issues that could be helpful for the local caseworker to know?

Note: A reporter is not required to know all of the above information when making a report; therefore, the lack of complete information does not prohibit a person from reporting. However, information to locate a child is crucial. When the alleged perpetrator cannot be identified the appropriate law enforcement agency/DA will be notified by SCR to assist with the case (NYSOCFS, 2011).

Written Report - LDSS-2221-A FORM (Report of Suspected Child Abuse or Maltreatment)

- Must be filed within **48** hours of verbal report to the appropriate CPS office.
- Document on the official form, obtainable from the Office of Children and Family Services (OCFS) Web site: http://ocfs.ny.gov/main/forms/cps/ldss-2221a%20report%20of%20suspected%20child%20abuse%20or%20maltreatment.doc
- Identical information as in telephone report (see above).
- Information should be written as clearly and objectively as possible.
- *It may be helpful to fill out the form before placing the call to SCR. This enables you to organize whatever demographic and identifying data, as well as the allegations and concerns that are most helpful for the case.*

  REMEMBER: The safety of the child must come before the completion of the form.

Note: Written reports are admissible as evidence in any judicial proceedings; accurate completion of the information is vital.

A mandated reporter who initiates an investigation of an allegation of child abuse or maltreatment, *is required* to comply with all requests for records made by CPS relating to such report**.**

What to Expect When Calling the SCR Hotline:

Sections 422.2(a) and 422.11 of the SSL establish the procedures to be followed by OCFS after the phone call is received.

There may be times when you have very little information on which to base your suspicion of abuse or maltreatment, but this should not prevent you from calling the SCR. A CPS specialist will help to determine if the information you are providing can be registered as a report.

The mandated reporter form can be used to help you organize the identifying or demographic information you have at your disposal.

Be sure to ask the CPS specialist for the "Call I.D." assigned to the report you have made as well as their full name.

If the SCR staff does not register the child abuse or maltreatment report, the reason for the decision should be clearly explained to you. You may also request to speak to a supervisor who can help make determinations in difficult or unusual cases.

When any allegations contained in the phone call could reasonably constitute a report of child abuse or maltreatment, including reports involving children who reside in residential facilities or programs, such allegations must be immediately transmitted by OCFS to the appropriate agency or local child protective service for investigation. If the department records indicate a previous report concerning a "subject of the report," other persons named in the report, or other pertinent information, the appropriate agency or local child protective service must be immediately notified of this fact.

Inquiring About the Report

- Section 422.4 of the SSL provides that a mandated reporter can receive, upon request, the findings of an investigation made pursuant to his/her report this request can be made to the SCR at the time of making the report or to the appropriate local CPS at any time thereafter. However, no information can be released unless the reporter's identity is confirmed.
- If the request for information is made prior to the completion of an investigation of a report, the released information shall be limited to whether the report is "indicated" (e.g., substantiated), "unfounded," or "under investigation," whichever the case may be.
- If the request for information is made after the completion of an investigation of a report, the released information shall be limited to whether a report is "indicated" or, if the report has been legally sealed.

Unfounded Reports

- Chapter 12 of the Laws of 1996 amended Section 422.5 of the SSL to legally seal, rather than expunge unfounded reports of child abuse or maltreatment.
- Section 422.5 of the SSL was amended by Chapter 136 of the Laws of 1999 to establish when a legally sealed unfounded report could be unsealed and to whom it could be made available.
- Legally sealed unfounded reports may be unsealed when:
    - There is another report involving a child named in the prior unfounded report.
    - Subsequent report involves subject of the unfounded report.
    - Fatality review teams need to prepare a fatality report.

Remember you only need reasonable cause to suspect the child is being abused.

- You do not have to prove it.
- A feeling of distrust or doubt is enough.
- Even if it is based on an actual observation or just a disclosure.

If you suspect imminent danger:

- Place distance between the child and harm.
- Harm could occur immediately or in the very near future.
- Try to determine how direct the threat is to the child.

Note: A subject of a legally sealed unfounded report may now obtain access to the report at any time when previously access had to be requested within 90 days of notification that the report had been unfounded.

TEST YOURSELF QUESTION #7:

Under New York State law, unfounded reports of child abuse are expunged and may never be unsealed.

A. True
B. False

Please turn to page 57 for answer.

Other Mandated or Authorized Actions

Photographs

According to NYS Child Protective Services Manual, Chapter IV, Section D.3g, p. 45, 2007:

Photographs can be an important source of evidence in a child abuse or neglect investigation.

- Provide information for child protective staff to consider, weigh, and evaluate in making a determination.
- Photographs graphically preserve visible evidence and accurately document the child's condition.
- Important not only for documenting the reasons for caseworker's decisions and actions, but can also be essential in presenting a case at a fair hearing or in family court.
- Photographs of children who may be victims of abuse or maltreatment should be taken or arranged for whenever there are visible physical injuries or trauma.

Mandated reporters, under certain circumstances, are required to take photographs.

Additionally, when a case is reported by a mandated reporter who is employed by an agency or institution which has the capacity to take high quality photos of injuries or trauma, CPS may choose to use the agency's photographs when CPS knows that they can have access to such photos as needed.

Certain guidelines should be followed to enhance the evidentiary value of the investigative photographs:

- All photos should be in color.
- Hard copies of photos should be obtained, especially when the photo is taken with a digital camera.
  - For 35 mm cameras, the negatives should be saved in the case file.
  - If the caseworker has the capacity to transfer images from the camera to a CD, that CD should be kept in the file as the digital original of the hard copy of the photos.
- Photos should accurately represent the scene or object and be free of distortion.
- Different views of the same scene should be taken.
- A full face photo should be taken for identification purposes, even if the trauma or injury does not appear in that area.
- A photo showing the relationship between the traumatized or injured area and the general area of the child's body should be taken. A close-up should be taken which shows the traumatized or injured area in more detail.
- The photo should be labeled with the date and time.
  - If the camera has this function, it should be used.
  - When a hard copy of the photo is obtained, the caseworker should label the back of the photo with a clear statement of the subject of the photo (e.g., Mr. Smith's living room at 123 Main St., Bob Smith's right arm, etc.).
- The photographer should be able to testify about the date and time each photo was taken and the camera location and direction.
  - It is not necessary for the photographer to appear in court for the photo to be entered into evidence.
  - If the camera does not have a date and time stamp, you can write the date and time on the actual photograph or write it on a sign to include when the photograph is taken.
  - The photo should be initialed by the person who took the photos and any witnesses to the taking of the photos.
- When taking the photos:
  - A neutral colored background and proper lighting is advisable.
  - Photo should not be 'artistic' or strive to appeal to emotions. It is evidence and should display the scene or subject as objectively as possible.
  - To the greatest extent possible, the photographer should photograph the child and/or injuries in a comforting non-threatening manner.

    - Keep in mind the child's potential to be fearful or embarrassed, or have negative emotional responses to the situation and the photograph.
- Where photographs have been taken by a mandated reporter, CPS staff should try to obtain those photos in conjunction with the mandated reporter's written report (Form LDSS-2221-A) or as soon thereafter as possible.
    - CPS is authorized to reimburse mandated reporters for expenses incurred in their taking of photos.
- All photos taken by CPS staff or other photographers and provided to CPS are part of the case record and must be kept secure and confidential with the local case record.

X-rays

- X-rays should be taken if medically indicated.
- Photos or x-rays must accompany the LDSS-2221-A, or be sent as soon as possible after its submission.
- Photos or x-rays should be appropriately identified with:
    - Child's name.
    - Date.
    - Name of person taking the photos or x-rays.

TEST YOURSELF QUESTION #8:

In terms of taking photographs of a child's visible trauma, a mandated reporter should:

A. Take photographs only if the hospital/police photographer is not available.
B. Take photographs only if a 35 mm camera is available.
C. Include the date and time the photo was taken.
D. Submit the highest quality photographs with the report.

Please turn to page 57 for answer.

Protective Custody

A child may be taken into protective custody (e.g., without court order or parental consent) if:

- The child is in such circumstance or condition that continuing to stay in his/her residence or in the care and custody of the parent or person legally responsible for the child's care presents an imminent danger to the child's life or health.
- There is not enough time to apply for an order of temporary removal from family court.
    - Protective custody should not be confused with status of a child admitted voluntarily to the hospital by the parents.

Persons legally authorized to place a child into protective custody:

- A peace officer (acting pursuant to his/her duties).
- A police officer.
- A law enforcement official.
- A designated employee of a city or county OCFS.
- A physician in their capacity as a member of staff of a hospital or similar institution.

Actions required of authorized persons:

- She/he must bring the child immediately to a place designated by the rules of family court for this purpose, unless the person is a physician treating the child and child is or will be presently admitted to a hospital.
- She/he must make every reasonable effort to inform the parent or other person legally responsible for the child's care of the facility to which the child has been brought.
- She/he must provide the parent or the person legally responsible with written notice, coincident with removal [Family Court Act (FCA) 1024(b) (iii)].
- She/he must inform the court and make a report of suspected child abuse or maltreatment pursuant to Title 6 of the SSL, as soon as possible [FCA, Sec. 1024(b)].
- She/he must immediately notify the appropriate local child protective service, which shall commence a child protective proceeding in family court at the next regular weekday session of the appropriate family court or recommend that the child be returned to his/her parents or guardian.
    - In neglect cases, pursuant to Section 1026 of the FCA, the authorized person or entity (usually CPS) may return a child prior to a child protective proceeding if it concludes there is no imminent risk to the child's health (NYSOCFS-CPS, 2007).

When a Report is Made

Investigation

- Goal: determine whether credible evidence exists.
- Local Department of Social Services is immediately notified for investigation and follow-up when a report is registered at the SCR.
- CPS contacts the source, the children, the parents/caregivers, school programs, physicians, health professionals, relatives, neighbors, police, and any other service provider or agency who might have information about the child.
- CPS contacts the mandated reporter.
- CPS evaluates the child and other children in the home.
- For court proceedings the mandated reporter's testimony and records may be requested.

Determination (Within 60 Days)

- A determination of risk to the children in the home is made.
  - Determination of reports is a difficult task.
  - No matter how thorough the investigation, sometimes there is no clear evidence of what happened.
- Indicated: there is reason to suspect that abuse occurred.
  - The report will remain on file at the SCR.
- Unfounded: determination that the evidence does not support claim.
  - The report is then sealed.
  - Sealed reports are expunged after a period of ten years from the date of the report.
- Mandated reporters may be informed of the outcome of the report if they wish.

Assessment/Service Planning

- An appropriate realistic service plan for the child and/or family must be developed to guard and ensure the child's well-being and development and to preserve and stabilize the family life.
- Services may be provided by CPS and other agencies and referrals to other agencies may be indicated.
- If there is immediate threat to the child's life or health, CPS may remove the child from the home.

Law Enforcement Referrals

When SCR staff receive information that leads them to believe there is an immediate threat to a child or that a crime has been committed against a child, but the SCR is unable to register a report (because it doesn't involve a parent or other person legally responsible for the child), the SCR staff will make a Law Enforcement Referral (LER). The relevant information will be recorded and transmitted to the New York State Police Information Network or to the New York City Special Victims Liaison Unit for action. Local CPS will not be involved (NYSOCFS, 2011).

TEST YOURSELF QUESTION #9:

After a report is filed, which of these actions does Child Protective Services usually take?

A. The child is immediately taken from the home.
B. The child's siblings are evaluated.
C. A surveillance team is placed outside the child's home.
D. The suspected child abuser is fingerprinted.

Please turn to page 57 for answer.

Legal Protection for Mandated Reporters

Immunity from Liability

To encourage prompt and complete reporting of suspected child abuse and maltreatment, SSL, Section 419, affords the reporter certain legal protections from liability.

- Any persons, officials, institutions who in good faith make a report, take photographs, and/or take protective custody, have immunity from all liability, civil or criminal, that might be a result of such actions.
- All persons, officials, or institutions who are required to report suspected child abuse or maltreatment are assumed to have done so in good faith as long as they were acting in the discharge of their official duties and within the scope of their employment and so long as these actions did not result from willful misconduct or gross negligence (NYSOCFS, 2011).

Source Confidentiality

SSL provides confidentiality for mandated reporters and all sources of child abuse and maltreatment reports. The Commissioner of Social Services, the local CPS, and local Children and Family Services (CFS) is not permitted to release to the subject of the report any data that would identify the source of the report unless the source has given written permission for the central processing center to do so. The person who made the report may also grant the local CPS permission to release her/his identity to the subject of the report. If a reporter needs reassurance, she or he should feel free to stress the need for confidentiality if the situation warrants. Information regarding the source of the report may be shared with court officials, police, and district attorneys, but only in certain circumstances (NYSOCFS, 2011).

Retaliatory Personnel Action

No medical or other public or private institution, school, facility, or agency shall take any retaliatory personnel action against an employee who made a report to the SCR.

No school, school official, child care provider, foster care provider, residential care facility provider, hospital, medical institution provider, or mental health facility provider shall impose any conditions, including prior approval or prior notification, upon member of their staff mandated to report suspected child abuse or maltreatment.

Consequences in New York State for Failing to Report

Legal Repercussions

Any person, official, or institution required by law to report a case of suspected child abuse or maltreatment that willfully fails to do so:

- May be guilty of a Class A misdemeanor and subject to criminal penalties.
- May be civilly liable (sued) for monetary damages for any harm caused by the mandated reporter's failure to make a report to the SCR.

Societal Repercussions

To protect children, suspicions of child abuse must be reported. CPS cannot act until child abuse is identified and reported, services cannot be offered to the family nor can the child be protected from suffering.

Professional Repercussions

In New York State it is considered professional misconduct for a professional not to report child abuse that occurs within the professional's work role. The New York State Education Department can charge professionals with unprofessional conduct leading to an investigation and potential censure, fine or license revocation (NYSOCFS, 2011).

TEST YOURSELF QUESTION #10:

In New York State, if a nurse does not report a suspected case of child abuse, it is considered:

A. a felony.
B. assault and battery.
C. an intentional tort.
D. professional misconduct.

Please turn to page 57 for answer.

Frequently Asked Questions

How many children are reported and investigated for abuse or neglect?

In 2013 in the U.S., an estimated 3.5 million referrals, involving the alleged maltreatment of approximately 6.4 million children, were received by CPS agencies. Sixty-one percent of these referrals were accepted for investigation by child protective services. Approximately 679,000 children were determined to be victims of child abuse or neglect by CPS agencies, which included 1,520 fatalities (U.S. Department of Health & Human Services, Administration for Children & Families, Administration on Children, Youth and Families, Children's Bureau [USDHHS, ACF, ACYF, CB], 2013).

In 2012, the NYS Central Register of Child Abuse and Maltreatment (the Child Abuse Reporting Hotline) received 161,992 reports of suspected child abuse or neglect. Upon investigation, 46,659 reports (29%) were substantiated as situations of child abuse and/or neglect. The number of victims of abuse and neglect in 2012 was 71,388. There are more children than reports because more than one child is involved in some cases. Compared to the prior year (2011), the number of reports decreased 2.7%, from 166,356; the number of substantiated reports decreased 3.6%, from 48,384; and the number of victims decreased 3.5% from 73,966 (Prevent Child Abuse-New York, n.d.).

How many children are victims of maltreatment?

An estimated 679,000 children nationwide were determined to be victims of child abuse or neglect in 2013. This is a decrease by 23,000 victims compared to 2009 when the estimate was approximately 702,000 victims. The victimization rate was highest for children younger than 1 year of age. Almost 74% (73.9%) of all child fatalities occurred in children under three years of age (USDHHS, ACF, ACYF, CB, 2013).

Is the number of abused or neglected children increasing?

Nationally the number of victims decreased 3.8% from 2009 to 2013. New York State experienced a 16.8% decrease of victims, with the numbers dropping from 77,620 victims in 2009 to 64,578 victims in 2013 (USDHHS, ACF, ACYF, CB, 2013).

Statistics continue to show that a child abuse victim is at high risk of suffering repeated abuse or neglect. Through the Child and Family Services Review, the Children's Bureau has established the current national standard for recurrence as 94.6%.

It is challenging to acquire comprehensive statistics regarding the true incidence of child abuse. Currently, the Department of Health and Human Services is conducting a study aimed at collecting statistics from various agency sources to develop a more accurate picture of the incidence of child abuse and neglect across the country. These new sources include law enforcement agencies, tribal jurisdictions, and other social service agencies that are currently not included (The National Exchange Club [NEC], 2013).

What are the most common types of maltreatment?

The majority (79.5%) of cases are classified as neglect, while 18% of cases are classified as physical abuse. It was determined that 9% of cases are due to sexual abuse, 8.7% of cases are due to psychological maltreatment, 2.3% are classified as medical neglect, and 10% of cases were due to "other" (USDHHS, ACF, ACYF, CB, 2013).

States may consider any condition that does not fall into one of the main categories — e.g. physical abuse, neglect, or emotional maltreatment — as "other." These maltreatment type percentages total more

than 100% because children who were victims of more than one type of maltreatment were counted for each incident (NEC, 2013).

Who are the child victims?

In 2013, 8.7 per 1,000 victims were boys and 9.5 per 1,000 victims were girls. CPS reported the approximate rates of child maltreatment victims as follows: 23.1 per 1,000 for infants less than 1 year old; 11.8 per 1,000 for 1 year-olds; 11.4 per 1,000 for 2 year-olds; 11 per 1,000 for 3 year-olds; 11.1 per 1,000 for 4 year-olds; with the number per 1,000 continuing to drop with each year to 3.5 per 1,000 for those age 17 (USDHHS, ACF, ACYF, CB, 2013).

In 2013, some children had higher rates of victimization in relation to gender and race disparities among other children: African-American (14.6 per 1,000 children), American Indian or Alaska Native (12.5 per 1,000 children), and multiracial (10.6 per 1,000 children). White, Hispanic and Pacific Islander child victimization rates (8.1, 8.5, and 7.9 respectively) averaged 8.2 per 1,000 children. The Asian population experienced significantly lower numbers of victims at 1.7 per 1,000 children (USDHHS, ACF, ACYF, CB, 2013).

How many children die from abuse or neglect?

Child fatalities are the most tragic consequence of maltreatment. The number of reported child fatalities due to child abuse and neglect has fluctuated during the past five years. It is estimated that nationally there were 1,520 child fatalities in 2013 (compared with an estimated 1,740 child fatalities in 2009) (USDHHS, ACF, ACYF, CB, 2013). This translates to a rate of 2.04 children per 100,000 children in the general population with an average of four (4) children dying every day from abuse or neglect (Child Welfare Information Gateway, 2012).

Research indicates very young children (ages three [3] and younger) are the most frequent victims of child fatalities, as they account for almost three-quarters (73.9%) of all child fatalities (USDHHS, ACF, ACYF, CB, 2013). The USDHHS, ACF, ACYF, CB, data for 2013 demonstrated children younger than one year accounted for 46.5% of the fatalities. This population of children is the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves (Child Welfare Information Gateway, 2013). Examining this percentage by single-year-age reveals the following data for child fatalities: 17.0% were 1 year old, 10.4% were 2 years old, and 7.1% were 3 years old (USDHHS, ACF, ACYF, CB, 2013).

The vulnerability of the youngest victims also is demonstrated by the rates of child fatalities. Children younger than 1 year died from child abuse and neglect at a rate of 18.09 per 100,000 children younger than 1 year in the population. Child fatality rates generally decreased with age. The child fatality rate of children in the age group of 16–17 was 0.21 per 100,000 children in the population of the same age group (USDHHS, ACF, ACYF, CB, 2013).

Boys had a higher child fatality rate than girls at 2.36 boys per 100,000 children in the population. Girls died of abuse and neglect at a rate of 1.77 per 100,000 children in the population (USDHHS, ACF, ACYF, CB, 2013).

Table 10. Maltreatment Types of Child Fatalities, 2013

Maltreatment Type	Child Fatalities	Maltreatment Types	
		Number	Percent
Medical Neglect		105	8.6
Neglect		869	71.4
Other		282	23.2
Physical Abuse		569	46.8
Psychological Abuse		22	1.8
Sexual Abuse		12	1.0
Unknown		1	0.1
National	**1,217**	**1,860**	**152.8**

Based on data from 45 states. A child may have suffered from more than one type of maltreatment and therefore, the total number of reported maltreatments exceeds the number of fatalities and the total percentage of reported maltreatments exceeds 100.0 percent. The percentages are calculated against the number of child fatalities in the reporting states.

Note: Reported data for types of maltreatment related to child fatalities for 2013, from 45 states. Adapted from USDHHS, ACF, ACYF, CB, (2013). Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf with permission.

Who abuses and neglects children?

Child maltreatment occurs across socio-economic, religious, cultural, racial, and ethnic groups (NEC, 2013). There is no single profile related to a perpetrator of child abuse, although certain characteristics reappear in many studies. Mothers make up 36.8% of the perpetrator population, compared to fathers at 19%; however 18.9% cited both parents as perpetrators (Prevent Child Abuse-New York, n.d.). Fathers and mothers' boyfriends are most often the perpetrators in abuse deaths; mothers are more often at fault in neglect fatalities (Child Welfare Information Gateway, 2015).

For 2013, four-fifths (83%) of perpetrators were between the ages of 18 and 44 years. For the first time, perpetrator data were analyzed by rate. The perpetrator age group of 25 – 34 had the highest rate at 5.0 per 1,000 adults in the population of the same age. Young adults in the age group of 18-24 had the second highest rate at 3.2 per 1,000 adults in the population of the same age. These findings are contrary to popular belief that young or teenage parents are the largest group of perpetrators of child abuse and neglect. Forty-five percent of perpetrators were men and more than one-half (53.9%) were women; 1.1% were of unknown sex (USDHHS, ACF, ACYF, CB, 2013).

Who reports child maltreatment?

Anyone can report suspected child abuse or neglect. Certain professionals are required by law to report suspected child abuse or maltreatment to the New York State Central Register (SCR) of Child Abuse and Maltreatment. The law also assigns civil and criminal liability to those professionals who do not comply with their mandated reporter responsibilities. In 2013, forty-nine states reported that 2.1 million reports received a CPS response, were completed and received some type of disposition. Just over 21% (679,000) of the 3.2 million children that received investigation or alternate response as a direct result of the submitted reports were found to be victims of maltreatment. Almost 80% (2.5 million children) of the 3.2 million children named in the reports, had all allegations found to be unsubstantiated or intentionally false; the children named in the reports were classified as "nonvictims" (USDHHS, ACF, ACYF, CB, 2013).

Professionals submitted almost three-fifths (61.6%) of the reports in 2013. "Professional" indicates that the report source came into contact with the alleged victim as part of the reporter's occupation. State laws require most professionals to notify CPS agencies of suspected maltreatment. The categories of

professionals include educators, legal and law enforcement personnel, social services personnel, medical personnel, mental health personnel, child daycare providers, and foster care providers, etc. The three most common sources of reports in 2013 were from professionals—educational personnel (17.5%), legal or law enforcement personnel (17.5%), social services personnel (11%) (USDHHS, ACF, ACYF, CB, 2013).

Nonprofessional report sources submitted one-fifth (18.6%) of reports. These included parents (6.7%), other relatives (6.9%), friends and neighbors (4.7%). Unclassified sources account for the remaining one-fifth of reports (USDHHS, ACF, ACYF, CB, 2013).

What happens after I make a report?

The Child Protective Services (CPS) unit of the local department of social services is required to begin an investigation of each report within 24 hours. The investigation should include an evaluation of the safety of the child named in the report, and any other children in the home, and a determination of the risk to the children if they continue to remain in the home.

CPS may take a child into protective custody if it is necessary for the protection from further abuse or maltreatment. Based upon an assessment of the circumstances, CPS may offer the family appropriate services. CPS has no legal authority to compel the family to accept such services. However, the CPS caseworker has the obligation and authority to petition family court to mandate services when they are necessary for the care and protection of a child.

CPS has 60 days after receiving the report to determine whether the report is "indicated" or "unfounded." The law requires CPS to provide written notice to the parents or other subjects of the report concerning the rights accorded to them by the New York State Social Services Law. The CPS investigator will document activities and decisions in the State Central Register file (NYSOCFS, 2011).

Are victims of child abuse more likely to engage in criminality later in life?

According to the National Institute of Justice (NIJ), maltreatment in childhood increases the likelihood of arrest as a juvenile by 59%, as an adult by 28%, and for a violent crime by 30%. A related NIJ report indicated that children who were sexually abused were 28 times more likely than a control group of non-abused children to be arrested for prostitution as an adult (National Institute of Justice, 2011).

Is there any evidence linking alcohol or other drug use to child maltreatment?

There is significant research that demonstrates this connection. Research has shown that among confirmed cases of child abuse and neglect, 40% involved the use of alcohol or other drugs. Substance abuse does not cause child abuse and neglect, but it is a distinct factor in its occurrence (NEC, 2013).

What is HIPAA and does it affect or limit my responsibility as a mandated reporter of suspected child abuse, neglect or maltreatment?

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. The privacy provisions contained in this regulation do not affect the responsibilities of mandated reporters, as they are defined in the New York State Social Services Law (NYSOCFS, 2011).

Information concerning the public health provisions of HIPAA may be found at http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/.

Answers to Test Yourself Questions

1. C (Answer can be found in Legal Definitions.)
2. D (Answer can be found in Key Assessment Factors.)
3. B (Answer can be found in Methamphetamine and Children at Risk)
4. D (Answer can be found in Assessing Physical Symptoms.)
5. D (Answer can be found in Sexual Abuse.)
6. D (Answer can be found in Reporting Child Abuse, Maltreatment or Neglect.)
7. B (Answer can be found in Reporting Procedures.)
8. C (Answer can be found in Other Mandated or Authorized Actions.)
9. B (Answer can be found in When a Report is Made.)
10. D (Answer can be found in Legal Protection for Mandated Reporters.)

Resources

Hotlines

New York State Child Abuse Hotline (mandated reporters/ reporting suspicions within professional capacity)	**1-800-635-1522**
New York State Child Abuse Hotline (general public/ reporting suspicions outside professional capacity)	**1-800-342-3720**
New York State Domestic Violence Hotline	**1-800-942-6906**
Runaway Hotline	**1-800-231-6946**
National Runaway Switchboard	**1-800-621-4000**
National Child Abuse Hotline	**1-800-792-5200**
Monroe County	**1-585-461-5690**
Onondaga County	**1-315-422-9701**

Compendium of Local, State and National Organizations and Agencies

American Humane Association
Children's Division
1400 16th Street NW, Suite 360
Washington, DC 20036
(800) 227 - 4645
http://www.americanhumane.org/

This is a national center promoting responsive child protection services in every community through program planning, training, education, and consultation. It operates the National Resource Center on Child Abuse and Neglect. Please contact for free general information.

CASA (Court Appointed Special Advocates) Advocates for Children of New York State (CASANYS)
911 Central Avenue #117
Albany, NY 12206
(315) 246 – 3558
Mail@casanys.org
http://www.casanys.org

In 1991, The New York State CASA Association was founded under the Task Force on Permanency Planning to promote and support trained community volunteer advocacy programs. The role of these programs is to assist family courts in making crucial decisions affecting children who have been abused and neglected.

Children's Defense Fund (CDF)
15 Maiden Lane, Suite 1200
New York, NY 10038
(212) 697-2323

This national advocacy organization focuses on the education, care, welfare, and health of children, and on federal legislation affecting children and families. CDF offers numerous publications on important issues in child health and family welfare.

Children of the Night
14530 Sylvan St.
Van Nuys, CA 91411
(818) 908-4474
Hotline: (800) 551-1300
www.childrenofthenight.org

This organization provides protection and support for street children, usually runaways, ages 11 – 17 who are involved in pornography or prostitution. Children of the Night provides shelter, a 24-hour hotline, and a street outreach program.

Child Welfare Information Gateway
Children's Bureau/ACYF
1250 Maryland Ave., SW, Eighth Floor
Washington, D.C. 20024
(800) 394-3366
www.childwelfare.gov

Child Welfare Information Gateway, formerly **National Clearinghouse on Child Abuse and Neglect (NCCAN)**, was established by the Child Abuse Prevention and Treatment Act in 1974. Its activities include conducting research, collecting and analyzing information, and providing assistance to states and communities for activities on the prevention of child abuse and neglect.

Child Welfare League of America (CWLA)
1726 M St. NW, Suite 500
Washington, DC, 20036
(202) 688 - 4200
www.cwla.org

This organization is comprised of public and private direct service agencies throughout the United States and Canada. CWLA offers a variety of publications and audiovisual materials for professionals.

Faith Trust Institute
2900 Eastlake Ave E.
Suite 200
Seattle, WA 98102
(206) 634-1903
http://www.faithtrustinstitute.org

Faith Trust Institute, formerly the **Center for Prevention of Sexual and Domestic Violence**, offers a wide range of services and resources, including training, consultation and educational materials, to provide communities and advocates with the tools and knowledge they need to address the religious and cultural issues related to abuse.

Family Support America
307 W 200 S
Suite 2004
Salt Lake City, UT 84101
www.familysupportamerica.org

This membership organization is comprised of social services, agencies concerned with family issues and preventive programs. FSA maintains a clearinghouse of information on family resource programs throughout the United States and Canada.

National Association of Counsel for Children (NACC)
13123 E. 16th Avenue, B390
Aurora, CO 80045
(888) 828-NACC
http://naccchildlaw.org

The center emphasizes the development of treatment programs for abused children, conducts training and consultation programs, and offers technical assistance. A catalog of materials and services is available upon request.

National Center for Missing and Exploited Children
699 Prince St.
Alexandria, VA 22314-3175
(703) 224-2150
Hotline: (800) 843-5678
www.missingkids.com

This nonprofit corporation operates a national resource and technical assistance center to deal with child abduction and exploitation.

National Coalition Against Domestic Violence (for members)
2000 M Street NW, Suite 480
Washington, DC 20036
(202) 467-8714
www.ncadv.org

The coalition is a national organization that works to end violence in the lives of battered women and their children. The coalition provides information, technical assistance, publications, newsletters, and resource materials. Call or write for membership information.

The National Network for Youth
741 8th Street, SE
Washington, DC 20003
(202) 783-7949
Hotline: (800) 786-2929
www.nn4youth.org

This organization works to ensure that young people can be safe and grow up to lead healthy and productive lives. It provides community youth development (CYD) services to members and communities. CYD is an approach that models the best practice in youth work and focuses on lifelong learning in which youth develop skills and competencies.

New York State Council on Children and Families
52 Washington Street West Building
Suite 99
Rensselaer, NY 12144
(518) 473-3652
http://ccf.ny.gov/

The NYS Council on Children and Families orients its priorities toward the development of comprehensive and coordinated systems of care that respond to the wide needs of children and families in New York.

New York State Domestic Violence Hotline
(800) 942-6906 Multilingual
Deaf or hard of hearing: 711
NYC: (800) 621-4673
www.opdv.ny.gov

In its capacity as the New York State Chapter of the National Committee for Prevention of Child Abuse, the Federation supports the activities of regional task forces throughout the state that assist communities in their efforts to prevent child abuse and neglect.

New York State Mandated Reporter Training
www.nysmandatedreporter.org

This site is designed to be a resource for information about the role and responsibility of a mandated reporter of child abuse and maltreatment in New York State. Through this site, training for all mandated reporters in New York State is available at no cost to participants.

New York State Office of Alcoholism and Substance Abuse Services
1450 Western Avenue
Albany, NY 12203-3526
(518) 473-3460 (General information)
http://www.oasas.ny.gov

The mission of OASAS is to improve the lives of New Yorkers by leading a premier system of addiction services through prevention, treatment, recovery.

New York State Office of Children and Family Services (OCFS)
52 Washington St.
Rensselaer, NY 12144
Hotline: 800-342-3720
(518) 473-7793
www.ocfs.state.ny.us

OCFS provides a variety of resource information related to child abuse and maltreatment/neglect specific to New York State. *Summary Guide for Mandated Reporters in NYS* can be obtained from this Web site, and is available in English, Spanish, Chinese, Russian and Arabic.

New York State Office for the Prevention of Domestic Violence (OPDV)
Alfred E. Smith Building
80 South Swan Street, 11th Floor
Room Number 1157
Albany, NY 12210
(518) 457-5800
http://www.opdv.ny.gov/

Created in 1983 as the Governor's Commission on Domestic Violence, this agency studies all aspects of domestic violence and develops recommendations for ways the state can more effectively help victims and their families. The office has initiated a diverse range of projects and produces a number of publications to help victimized family members.

NYS Office of the Professions
State Education Building - 2nd Floor
Albany, NY 12234
(518) 474-3817
http://www.op.nysed.gov/training/caproviders.htm

The Office of the Professions provides a number of services to the public and the professions, including licensure and registration, professional discipline, and public and professional education and information. Their Web site identifies, by region, approved providers of training for Child Abuse Identification and Reporting.

Prevent Child Abuse America (PCAA)
228 South Wabash Avenue, 10th Floor
Chicago, IL 60604
(312) 663-3520
Info. & Referral: (800) 244-5373
www.preventchildabuse.org

This organization is committed to the reduction of child abuse and neglect through public awareness, education, research and advocacy. PCAA coordinates chapters at the state level and is a primary resource for local child abuse and neglect prevention efforts. A number of publications on the prevention of child abuse and neglect are produced by PCAA.

Prevent Child Abuse New York
33 Elk St, Suite 201
Albany, NY 12207
(518) 445-1273
24 hour Prevention and Parent Helpline: (800) 244-5373
www.preventchildabuseny.org

This is the New York State Chapter of Prevent Child Abuse America. Programs include:

- The Prevention Information Resource Center and Parent Helpline (24 hour hotline).
- Healthy Families New York.
- Public awareness and education.
- Advocacy.
- Annual Legislative and Prevention Conferences.

The programs are an integrated whole, offering prevention services that begin with the needs of the child, the family, and the community they live in; expands to the human services and volunteer community that supports them; and reaches out to the public officials and public policy makers who have an ultimate responsibility to assure that every child has a protected childhood and people who can guide them to a successful future in safe communities. Both English and Spanish services are offered.

Social Services Laws of New York State regarding Child Abuse
http://public.leginfo.state.ny.us/menuf.cgi

Click on the Laws of New York link under the Search heading to access an alphabetical list of links to NYS consolidated laws.

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Child Abuse in NYS: Identification and Reporting

Course Exam

After studying the downloaded course and completing the course exam, you need to enter your answers online. Answers cannot be graded from this downloadable version of the course. To enter your answers online, go to e-leaRN's Web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, log in using the username and password you created, click on the "Go to Course" link and proceed to the course exam.

Note: Contact hours/CEUs will be awarded for this course until **December 17, 2018**.

1. Which of these occurrences may be considered child abuse?

    a. Holding the penis of a four-year-old child when he urinates.
    b. Kissing a ten-year-old child near the mouth.
    c. Having sexual activity with a consenting 14-year-old boy.
    d. Hiring a 19-year-old female prostitute.

2. Children are ***most*** often physically abused by:

    a. Strangers.
    b. Older children.
    c. Their teachers.
    d. Their parents.

3. The chemicals involved in methamphetamine production are:

    a. Generally safe household items.
    b. Toxic and highly irritating to skin, eyes, and lungs.
    c. Are used under controlled conditions by trained laboratory technicians.
    d. None of the above.

4. Meth use contributes to domestic violence, child abuse, automobile accidents, and the spread of infectious diseases such as Hepatitis C and HIV.

    a. True
    b. False

5. Child abuse/neglect, burns to the skin, and respiratory ailments may signal a drug-endangered child.

    a. True
    b. False

6. If you suspect a clandestine meth lab, which of the following agencies may become involved?

    a. Local law enforcement
    b. HAZMAT
    c. Social Services
    d. All of the above

7. Physical signs that almost always indicate child abuse are:

    a. Bruises.
    b. Lacerations.
    c. Persistent diaper rash.
    d. Injuries to both eyes or both cheeks.

8. A burn that should be considered a physical indicator of child abuse is one that:

    a. Occurs during the night.
    b. Has a patterned design.
    c. Affects one limb only.
    d. Is nearly healed on first presentation.

9. Special attention should be paid to a child's injuries when they are:

    a. Easily explained by parent/caretaker.
    b. Consistent with the explanations given.
    c. Inconsistent with the child's developmental stage.
    d. Explained with a great deal of emotion by parent/caretaker.

10. Which of these behavioral signs is ***most*** likely to indicate that a 6-year-old child has been physically abused?

    a. Is frightened when other children cry.
    b. Wears only long-sleeved shirts despite hot weather.
    c. Will drink only warmed liquids.
    d. Has erratic eating habits, often refusing to eat.

11. Which of the following is ***least*** likely to be an indicator of maltreatment and/or neglect in a 12 year old child?

    a. Chronic truancy.
    b. Use of profanity.
    c. Untreated physical problems.
    d. Delayed physical development.

12. Family histories can reveal clues that suggest further investigation is warranted if child abuse is suspected. Which of the following is such a clue?

    a. Grandparents were divorced.
    b. Single parent family.
    c. Parent who stutters.
    d. Parent was abused as a child.

13. Which of the following parent/child interactions warrants further assessment for a possible report of abuse?

    a. Parent verbalizes mental limits of a child who is developmentally disabled.
    b. Parent appears to be nurtured or cared for by child.
    c. Parent frequently attends school activities with child.
    d. Parent appears overly concerned with the child's shyness

14. A 2-year old toddler is brought into your emergency room with pain and restricted movement in the upper right arm. His parents state he fell off his tricycle. An X-ray reveals a spiral fracture of the humerus. You would:

    a. Educate the parents about bike safety.
    b. Question the parents further about the accident.
    c. Report the suspicion of child abuse immediately.
    d. Advise the parents to seek counseling.

15. Environmental factors that are associated with abusive behavior include:

    a. Frequent moves to new residences.
    b. Presence of extended family in or near the home.
    c. Television sets in each room of the residence.
    d. Sharing of bedrooms by children of the opposite sex.

16. Which of the following behaviors demonstrated by a 15-year-old boy is ***most*** likely a sign of maltreatment and neglect?

    a. He often wears no coat to school despite below zero weather.
    b. He earns a "C" average in school.
    c. He enjoys playing violent video games.
    d. He is compliant and passive.

17. Which of the following behaviors is the ***most*** likely sign of current or previous sexual abuse?

    a. A 14-year-old boy has poor peer relationships.
    b. A 15-year-old girl who wears revealing clothing.
    c. A 16-year-old girl is sexually active.
    d. A 12-year-old boy sexually assaulted a younger child.

18. Which of these actions by a mandated reporter is often crucial to protect a child from further abuse?

    a. Reporting the suspicion of abuse immediately.
    b. Collecting more evidence about the abuse.
    c. Having the child examined by a physician immediately.
    d. Contacting the parent to discuss the situation.

Use the following situations for questions 19- 21.

A. A 4-year-old girl with gonorrhea.
B. A 4-week-old infant who fractured his skull falling out of his crib.
C. A 3-year-old and her 3-month-old brother who stay alone while their mother works.
D. A 12-year-old with a fractured collarbone and leg that he says he injured on a friend's skateboard.

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19. Which of the situations is ***most*** likely to indicate possible neglect?

    a. A
    b. B
    c. C
    d. D

20. Which of the situations is ***most*** likely to indicate possible physical abuse?

    a. A
    b. B
    c. C
    d. D

21. Which of the situations is ***most*** likely to indicate possible sexual abuse?

    a. A
    b. B
    c. C
    d. D

22. Is it true that in order to possess the necessary "reasonable cause" to file a report of child abuse, the reporter must be certain that the injury was caused by neglect or non-accidental means?

    a. Yes; otherwise, the reporter is making a libelous claim.
    b. Yes; otherwise, the reporter may have his/her license revoked.
    c. No; any suspicion whatsoever must be reported.
    d. No; if there is a professional judgment, a report should be filed.

23. In terms of taking photographs of a child's visible trauma, a mandated reporter should:

    a. Take photographs only if the hospital/police photographer is not available.
    b. Take photographs only if a 35 mm camera is available.
    c. Include the date and time the photo was taken.
    d. Submit the highest quality photographs with the report.

24. Which of the following statements is true concerning a mandated report of child abuse?

    a. Reporters are presumed to have done so in good faith.
    b. Reporters are professionally liable within their scope of practice for their statements.
    c. The name of the reporter is released only to the subject of a report.
    d. The reporter must appear in court if charges against the parent are filed.

25. Under New York State law, is it possible for an individual over 18 years of age, who has a disability and resides in a New York state-approved residential care facility, to be classified as an abused child?

    a. No, since the person is over the age limit.
    b. No, since the person is considered a ward of the state.
    c. Yes, this person can be included in this classification.
    d. Yes, but only if mentally compromised.

26. After a report is filed, which of these actions does Child Protective Services usually take?

    a. The child is immediately taken from the home.
    b. The child's siblings are evaluated.
    c. A surveillance team is placed outside the child's home.
    d. The suspected child abuser is fingerprinted.

27. In the event the mandated reporter makes a verbal telephone report of child abuse, a written report must be filed within:

    a. 24 hours.
    b. 48 hours.
    c. 3 days.
    d. 7 days.

28. A 10-year old girl asks the school nurse, “What would happen if someone told you that her father touched her in a private place?” Based on this comment, which of these actions should the nurse take ***initially***?

    a. Encourage the child to tell the nurse what the child knows about the girl.
    b. Find out from the child’s teacher what has been going on in class.
    c. File a written report of suspected sexual abuse.
    d. Contact the child’s family.

29. A mandated reporter is treating a woman in the emergency department of a hospital. She tells the clinician that her husband “is not a good father.” He constantly hits her son, calls him “unmentionable” names, and often sends him to bed without dinner. The child has lost weight but says he loves his father. Is this situation considered reportable?

    a. No, this is hearsay and as a mandated reporter you cannot act on this information.
    b. No, this child needs a medical referral.
    c. Yes, this father’s behavior is considered abusive, and as a mandated reporter you must report what this patient is telling you.
    d. Yes, any poor parenting must be reported as child abuse.

30. In New York State, if a nurse does not report a suspected case of child abuse, it is considered:

    a. A felony.
    b. Assault and battery.
    c. An intentional tort.
    d. Professional misconduct